DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
HEALTH POLICY & SERVICES DIVISION

MARC RACICOT
GOVERNOR

LAURIE EKANGER
DIRECTOR

STATE OF MONTANA

COGSWELL BLDG., 1400 BROADWAY
PO BOX 202951
HELENA, MONTANA 59620-2951

December 27, 1999

Diona Kristian
HCFA—MSO
Mail Stop C4-14-16
7500 Security Blvd.
Baltimore MD 21244

Dear Ms. Kristian:

It is with pleasure that we submit this Amendment to the State Plan for Montana's Children's Health Insurance Plan (CHIP). HCFA approved Montana's State Plan on September 11, 1998. I call your attention to the following changes, reflected in the enclosed Amendment, to Montana's CHIP program since our original State Plan was approved:

1. Montana's 1999 Legislature passed Senate Bill 81, creating CHIP and appropriating State funding to draw down the full Federal match. Montana's appropriation is for two years and is funded by Montana's share of the multi-state Tobacco Settlement.

2. Montana originally planned to contract with an enrollment broker to perform eligibility, enrollment, and outreach functions for CHIP. We have since reevaluated this plan and decided to perform those functions in-house using State employees.

3. Montana is proposing to change the required time to process CHIP applications from *within five* ***working days*** to ***within 10 working days.*** We understand no other state has been held to the five-day requirement.

PHONE: (406) 444-4540 **FAX:** (406) 444-1861

4. Montana has developed a Universal Form for application to CHIP, Medicaid, Special Health Services, the Mental Health Services Plan, and the Caring Program. This Universal Form will streamline the application process for families, helping to reduce barriers to children becoming enrolled in health care programs for which they qualify.

5. Montana's 1999 Legislature changed CHIP benefits as follows:

   - Birth control contraceptives are no longer a covered benefit.
   - Dental services were added.
   - Eyeglass benefits were added.

Questions about the Montana State CHIP Plan can be directed to Mary Noel at the Department of Public Health and Human Services. She can be reached by telephone at **406-444-6992,** by fax at **406-444-4533,** or by email at manoel@state.mt.us.

Sincerely,

Laurie Ekanger
Director
Department of Public Health and Human Services

STATE CHILD HEALTH PLAN
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State: MONTANA

State Plan
Amended December 27,1999
Amendment Number one

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

_____

(Signature of Director of Montana Department of Public Health and Human Services, Date Signed)

submits the following Amendment to the State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuance of the Department.

MONTANA'S CHILDREN'S HEALTH INSURANCE PLAN

INDEX

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

1.1. ☒ **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR**

1.2. ☐ **Providing expanded benefits under the State's Medicaid plan (Title XIX); OR**

1.3. ☐ **A combination of both of the above.**

Overview

Montana is pleased to submit the First Amendment to our Title XXI State Plan to expand children's access to health coverage. Montana's Children's Health Insurance Plan (CHIP) purchases insurance for each enrolled child. Our target population is children ages zero through eighteen living at or below 150% of the federal poverty level. Financial eligibility is based on a family's adjusted gross income. There are no asset or resource tests.

Benefit coverage is based on a benchmark equivalent package. Covered benefits include inpatient and outpatient hospital services, physician and advanced-practice registered nurse services, lab and X-ray, well-child and well-baby services including age appropriate immunizations, prescription drugs, mental health and substance abuse treatment services, and hearing and vision exams, eyeglasses, and dental services.

Families may obtain health insurance from an indemnity insurance plan or a health maintenance organization (HMO) Families are given a choice of the type coverage they wish for their children. The choice depends on the geographic availability of the insurance product in a family's area and an insurance carrier's willingness to participate.

Families living at 100% to 150% of the federal poverty level share in the cost of CHIP through an annual enrollment fee and a copayment when services are received. No enrollment fee or copayment applies for families living below 100% of the federal poverty level. No copayment applies to well-baby or well-child care including age-appropriate immunizations. Native American Indian families are excluded from cost-sharing.

Montana's CHIP program is not an entitlement. The legislature appropriates funds for CHIP each biennium. Enrollment is limited based on State funding and any private donations available to the program.

Implementation of CHIP has been and will continue to be a collaborative process. The program was developed with the assistance of a broad-based advisory council and several legislative committees. Public comment was actively solicited and received in numerous forums.

The Health Policy and Services Division of the Montana Department of Public Health and Human Services (DPHHS) administers CHIP. The Division includes public health specialists who administer the Title V Maternal and Child Health Block Grant and the Title X family planning grant, and Medicaid specialists who administer acute and primary services. These bureaus of DPHHS were integral in the design of CHIP.

Montana's State Plan was approved by HCFA on September 11, **1998.** HCFA approved both phases of a two-phase approach to implement the Children's Health Insurance Plan. Montana's legislature met in January **1997 and** did not convene again until January **1999;** we started Phase I of CHIP with a **$21**0,000 intergovernmental transfer from the Office of the Commissioner of Insurance.

Phase I, sometimes referred to as the "Pilot," began in January **1999,** serving **943** children. Contracts were negotiated with insurance companies. Eligibility, enrollment, and management information system infrastructures were built, and identification of additional revenue sources for the state match were identified.

In April **1999,** the Montana Legislature appropriated the state match to allow Montana to draw down its full Federal CHIP allotment. The Legislature passed Senate Bill **8**1 that describes the cost-sharing mechanisms, benefit package, and children to be targeted. The State's match of program costs was funded from Montana's share of the multi-state Tobacco Settlement.

CHIP Phase II began October 1, **1999.** Montana's federal allotment and State match will allow us to insure **10,100** children. On December 1, **1999,** after only two months, Montana had enrolled 2,500 children, one-fourth of its goal. Extensive marketing and outreach efforts are slated to begin in January 2000.

Montana will conduct CHIP in compliance with all applicable civil rights requirements.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Montana has little data on the insurance status of its children. The only information available to us when we submitted our State Plan in **1998** was from the **US** Census Bureau. We cannot independently validate the census estimates. We provided these preliminary estimates in our State Plan at HCFA's request. We were unable to present data broken out by race, ethnicity, or geographic location.

Category	No. Children per Census Data CY 97	No. Estimated Uninsured CY 97
Aae Under 5	13.509	3.148
Age 12-17	14,847	3,459
Age 18	3.538	925
Total 100%	50,561	11,881
150% FPL		
Age Under 5	21,295	3,769
Age 5-11	31,106	5,505
Age 12-17	24.712	4.373
Age 18	5,234	1,039
Total 150%	82,347	14,686
200% FPL		
Age Under 5	29,956	4,742
Age 5-11	44,921	7,111
Age 12-17	35,328	5,592
Age 18	6,701	1,190
Total 200%	116,906	18,635
All Incomes		
Age Under 5	55,660	5,598
Age 5-11	90,359	9,614
Age 12-17	86,732	10,176
Age 18	12,252	1,612
Total All Incomes	245,003	27,000

Data is cumulative for each age group and total. **A** September 1997 US Census Bureau document estimates the number of children who are uninsured at 23.3% of those 18 and under below the poverty level. Children on Medicaid are counted as insured. This is a national statistic that does not reflect individual state experiences. Each state has different eligibility requirements that are based on

poverty levels. Older children were less likely to have health care coverage than younger children. 13.8% of children under 6, 14.6% of children 6-11, and 16.1% of children 12-17 were estimated to be uninsured.

Further estimates are based on **US** Census Bureau reports on Low Income Uninsured Children by State. In Montana, the number and percent of children under 19 years of age, at or below 200% of poverty, for 1994,1995, and 1996 is 120,000 children or 48.1% of the population under 19 years of age. Those estimated to be without insurance were 19,000 or 7.9% of the population under age 19. This is 15.83%(19,000/120,000) of those at or below 200% of poverty. The Children's Defense Fund estimates the number of children in Montana who are 18 years of age or younger and without health insurance to be 27,000 or 10.7% of the population of that age group.

Questions will be added to the Behavioral Risk Factor Surveillance Survey (BRFSS) to determine whether there are children in the family and whether they have creditable insurance coverage. Using the same questions on each subsequent BRFSS will allow us to measure our progress.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Montana currently has several efforts in place to identify and enroll children who are not presently covered by health insurance but who may be eligible to participate in Medicaid or to receive public health services. Public health core functions include the responsibility to assess health care needs and resources, including access to health services and insurance, and to assure access by being knowledgeable about available resources, referring appropriately, and providing services if no other option exists.

Montana's services and programs intended to assure access include:

1. Public health referral systems — Women's, Infants' and Children's (WIC) Nutrition programs and public health home visiting services include assessment of high-risk conditions such as developmental, nutritional, psycho-social, and income factors. Clients with access needs are referred to eligibility workers in local settings who determine whether the client is eligible to be covered by Medicaid. In the case of programs for high-risk pregnant women, home visiting services and others may also do an initial screen for

Medicaid eligibility authorizing clients for presumptive eligibility. WIC is funded with United States Department of Agriculture funding and public health home visiting is funded with a combination of Title V and State general fund resources.

2. Federally Qualified Health Centers—Montana has twelve federally qualified health centers, including six Community Health Centers (CHCs), five urban Indian clinics and one Migrant Health Clinic. Each of these facilities has the resources necessary to determine presumptive Medicaid eligibility, and has applications for CHIP and the Caring Program for Children. CHCs must also provide services regardless of the ability to pay. Four of the Community Health Centers are co-located with public health departments and referrals between services are made to assure access.

Community Health Centers use standard procedures to determine appropriate pay level for each client including providing a financial screen for each new patient or family, providing information on and explanation of services for which family members are eligible, assisting with completing applications and collecting required documentation, determining eligibility on-site or forwarding applications to the determining agency, communicating with family members about eligibility status, and assisting families when their financial situation and eligibility changes.

3. The Caring Program for Children—A public-private partnership administered by Blue Cross Blue Shield of Montana, to provide preventive medical, dental, and vision services, as well as outpatient diagnostic, emergency, accident and surgical services. Children ages eighteen and under who are "not currently covered under a state or federal medical assistance program (i.e., Medicaid) or under any private health insurance program" are eligible for the program. The Caring Program is not licensed as, nor does it function as, an insurance product in Montana. Clients determined eligible for Medicaid in the screening process are referred to the appropriate local agency. Enrollment in the Caring Program is dependent on donations to cover health care.

4. Children's Special Health Services (CSHS)—Provides coverage for a limited number of children who have special health care needs. This program provides reimbursement for health care charges if the charges are not covered by Medicaid or other health care insurance. The application for the CSHS program includes income determination to screen for Medicaid eligibility. CSHS program activities are funded with Title V resources.

5. Family Planning programs—Contract services that identify clients in need of primary care services. They specifically target low-income clients. These clinics identify funding sources available to pay for preventive health services, including Medicaid and other insurance, and refer clients appropriately to those resources. The state funds Family Planning clinics with Title X funding, and local contributions may include Title V and other resources.

6. Rural Health Clinics (RHC) and National Health Service Corp (NHSC) providers—A loose network of primary care services throughout the state that allows clients to pay on a sliding fee scale. Twenty-three RHCs provide services on a sliding fee scale, and twelve NHSC providers located in federally designated shortage areas provide services on a sliding fee scale. RHCs may refuse service to clients, but NHSC must accept any client regardless of ability to pay.

7. Part C of the Individuals with Disabilities Education Act—Provides statewide early intervention services to meet the needs of Montana's infants and toddlers with diagnosed disabilities or with developmental delays that warrant concern for a child's future development. Children deemed eligible for Part C Services in Montana who appear to be Medicaid eligible are referred to the local county office for Medicaid determination.

8. Montana's Mental Health Services Plan (MHSP)—Provides mental health services through a single statewide fee-for-service program. MHSP is not an insurance plan. MHSP contains two components. The Medicaid portion of the program operates under a 1915(b) waiver. The "state-only" portion of the program serves people of all ages below 150% of poverty who have a serious emotional disturbance or severe mental illness. Eligibility determinations are performed by DPHHS. Clients who appear to be eligible for Medicaid in the screening process are referred to the appropriate county office.

9. Medicaid—Provides health coverage for low-income, elderly, and disabled Montanans. Infants born to Medicaid-enrolled women remain eligible for Medicaid for twelve months. Children ages zero through five are covered at 133% of poverty, ages six through 16 are covered at 100% of poverty, and ages seventeen and eighteen are covered at 40.5% of poverty. The Department of Public Health and Human Services administers Medicaid. County public assistance offices determine eligibility for Medicaid, TANF, and food stamps.

Presumptive eligibility sites for pregnant women and outstationed eligibility sites for Medicaid include Federally Qualified Health Centers, Health Care Clinics, Migrant Health Clinics, Tribal Health clinics, and Indian Health Services facilities. Staff at these sites help people apply for Medicaid by providing assistance in completing the application and then forwarding the application to county public assistance offices for eligibility determination. Outreach to inform potential recipients about Medicaid is accomplished through the resources previously noted and by distributing Medicaid information to many health care advocacy groups and providers in Montana. Montana anticipates reaching thousands of children in the CHIP outreach process, many of whom will be eligible for Medicaid.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

Montana currently has no health insurance programs that involve a public-private partnership.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:
(Section 2102)(a)(3)

Montana's outreach and enrollment efforts will be designed to maximize the number of children served under the Medicaid and CHIP programs. (We have no health insurance programs that involve a public-private partnership.) The state plans to coordinate the Children's Health Insurance Plan enrollment efforts with:

- Medicaid
- Local public health departments
- WIC
- School Nutrition and Health Programs
- Federally Qualified Health Care Centers which include Community, Urban Indian, and Migrant Health Centers
- Case Management Providers
- The Caring Program for Children
- Family Planning and Planned Parenthood Centers
- Rural Health Clinics
- Mental Health Services Plan

- Children with Special Health Care Needs Program
- County Eligibility Examiners and Families Achieving Independence in Montana (FAIM) Coordinators
- Indian Health Services
- Tribal Health Services
- Early Intervention Services (Part C)
- Child Support Enforcement
- Child Protective Services
- Head Start and Early Head Start
- Montana's Covering Kids grantee
- Other Programs as they are identified

These providers will:

- Inform participants in their programs of the Children's Health Insurance Plan
- Distribute brochures and application forms for the Children's Health Insurance Plan

Special outreach and coordination efforts will take place between CHIP, Medicaid, and the Caring Program. Medicaid applicants with children who do not qualify for Medicaid will be asked to sign a release form permitting the information provided on their Medicaid application to be used to determine if the child may be eligible for the Children's Health Insurance Plan.

Montana will ensure that Medicaid-eligible children are enrolled in Medicaid. CHIP applicants who appear to be Medicaid-eligible are referred to their local Office of Public Assistance if the family has given CHIP permission to forward their information.

Because the Caring Program provides only primary and preventive health care and is not an insurance product, children currently on this program are allowed to choose to stay with this program or apply for CHIP.

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

Montana's population is approximately 880,000. Of this number, only 23,130 people receive health care services through a Health Maintenance Organization (HMO). 2,269 of these HMO participants are Medicaid recipients. The low penetration rate for managed care requires that Montana rely primarily on indemnity insurance plans for coverage for the CHIP program. We will contract with as many indemnity plans as are willing to meet our contracting criteria. In this way we hope to offer clients a choice in the more populated areas of the state. In the areas where an HMO is geographically available, clients will be offered this choice as well. As of December 1999, we contract with one indemnity plan, Blue Cross Blue Shield of Montana, and no HMOs.

Contracts with indemnity insurance plans and HMOs address the following areas: cost sharing, enrollment, marketing, benefits, premiums, provider network, utilization management, quality of care, access to care, member rights, and grievance procedures. Contract standards are based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and existing Medicaid managed care contracts.

Montana may vary significantly from provider standards established in other states. Montana is a frontier state characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, we are unable to use a single distance and/or travel time to gauge adequacy of a provider network. Instead, we decide availability of primary care practitioners and specialists in the normal service delivery area for each town or locale. This has proven successful in our Medicaid PASSPORT program (our primary care case management model) that has been in operation since 1993. This methodology is also the basis for legislation passed to ensure network adequacy for commercial HMOs operating in Montana. We find in a frontier state such as Montana this case-by-case approach is more meaningful to clients who are accustomed to, and often choose to, live extended distances from services.

Essential Community Providers:
Indemnity insurance plans and HMOs are required to offer Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Title X Family Planning providers, Indian Health Service providers, Tribal Health providers, Urban Indian Centers, Migrant Health Centers and county public health departments who serve

enrollees a provider network contract. The contract must offer terms and conditions at least as favorable as those offered to other entities providing the same or similar services. This provision is only in effect, however, if the afore-named entities substantially meet the same access and credentialing criteria as other contract providers and only for geographic areas jointly served by the entities and the plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

HMOs and indemnity insurance plans that contract with CHIP perform primary utilization management functions. Contract standards require a participating insurer or HMO to have adequate staff and procedures to ensure that services provided to enrollees are medically necessary and appropriate. At a minimum the plans must address the use of referrals, prior authorizations, and client educational services.

Plans are encouraged to use a primary care provider (PCP) to serve as a child's medical home. The PCP should perform all routine non-emergency care for the child and make necessary arrangements for a child who needs referral to a specialist or hospital. A specialist could serve as a child's primary care provider. The state Medicaid program has extensive experience in using a PCP system and offers technical assistance to insurance plans.

Plans will include in their educational materials for enrollees and providers information about additional services available to children with special health care needs. Examples of these services are the Mental Health Services Plan, the state program for Children with Special Health Care Needs, public health case management services for pregnant women and children, and Part C.

Section **4.** Eligibility Standards and Methodology. **(Section 2102(b))**

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section ***5.***

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A))**

4.1.1 ☐ Geographic area served by the Plan:

4.1.2 ☒ Age: The plan is available to children ages zero through eighteen. Coverage for a child will continue through the end of the month of the child's 19* birthday.

4.1.3 ☒ Income: Children from families whose adjusted gross income (as defined for federal income tax purposes) is at or below 150% of the federal poverty level are eligible. Earned (wages, tips, salaries, etc.) and unearned (child support, unemployment, etc.) income will be counted when determining adjusted gross income. Any income excluded by other federal statute will not be counted.

The applicant must provide verification of income that could include wage or salary pay stubs, W-2 forms, the most recent income tax returns (state or federal), an employer's payroll records, or an employer's written statement of earnings.

For purposes of determining financial eligibility for CHIP, a family unit consists of:

1. The child for whom the family is applying
2. The natural or adoptive parents of the child
3. Spouses residing together
4. Siblings (natural, adoptive, half, or stepbrothers/sisters) from ages zero through eighteen, with the following exception: If a sibling is between ages nineteen through twenty-two is attending an institute of higher learning, he or she may be counted in the family unit.

An emancipated minor who applies for CHIP is considered his or her own family.

4.1.4 ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5 ☒ **Residency:** U.S. Citizenship and Montana residency are required. A Montana resident is anyone who declares him-or-herself to be living in the state, including migrant and other seasonal workers. The parent will be required to certify on the application that the child is a U.S. citizen or Qualified Alien and a Montana resident. Montana will follow federal guidelines in determining whether a child is a **U.S.** citizen or Qualified Alien and eligible for CHIP.

4.1.6 ☐ **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will be denied coverage because of eligibility for Medicaid, not for disability status.

4.1.7 ☐ **Access to or coverage under other health coverage:** A child will be found ineligible when: 1) the child is covered under a group health plan or under health insurance coverage as defined in section 2791 of the Public Health Service Act; 2) the child is eligible for Medicaid; **3)** the child is eligible to receive health insurance benefits under Montana's state employee benefit plan; or 4) the child is not a **U.S.** citizen or Qualified Alien as defined under federal statute.

4.1.8 ☐ **Duration of eligibility:** Once a child has been accepted, he or she remains eligible for one year from the date of enrollment in CHIP unless the child moves from the state, is enrolled in Medicaid, or is found to have other creditable coverage.

4.1.9 ☒ **Other standards (identify and describe):** Usually a child will be ineligible for CHIP if the child has been covered under an individual or group health plan during the three months prior to application for CHIP. If, however, a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, has an employer who no longer provides dependent health insurance coverage, has a lapse in insurance coverage because he or she obtains new employment, or if the parent dies, the three-month waiting period for the Children's Health Insurance Plan will not apply.

If a child becomes an inmate of a public institution, CHIP coverage will terminate.

4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(a)(B))

4.2.1 ☒ **These standards do not discriminate on the basis of diagnosis.**

4.2.2 ☒ **Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.**

4.2.3 ☒ **These standards do not deny eligibility based on a child having a pre-existing medical condition.**

4.3 Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102 (b)(2))**

Montana has used separate applications for the Children's Health Insurance Plan and the Medicaid program. CHIP considers family income in determining eligibility. Montana Medicaid also considers a family's assets and resources. Families who have completed a Medicaid application and who have been denied may submit the Medicaid application instead of the CHIP form. It has been necessary, however, for families who are determined potentially eligible for Medicaid during application for CHIP to complete the regular Medicaid application.

Beginning January 1,2000, Montana will begin using one application for children's health coverage programs. Programs using the form include: CHIP, Medicaid, CSHS, Mental Health Services Plan, and the Caring Program. Use of the Universal Form will allow families to apply for more than one program for their child without completing several application forms and supplying duplicate verification documents.

CHIP screens applicants for Medicaid eligibility. If the family income suggests probable eligibility for Medicaid, CHIP notifies the family in writing that the child cannot be insured by the Children's Health Insurance Plan because the child appears to be eligible for Medicaid. The letter contains a telephone number the family may call for assistance. The CHIP application and the Universal Form have a check-off box that families may mark if they do not want information from the form to be forwarded to their local county Public Assistance office to begin the Medicaid application process. If the family checks this box, no information is forwarded. Whether the family agrees to forward this information or not, families are given a reminder of the importance of applying for Medicaid and the greater benefits provided by Medicaid. In all instances, children who appear to be Medicaid eligible will only be enrolled in CHIP after they have received a denial letter from Medicaid or if CHIP is otherwise notified by the local Office of Public Assistance that the child is not eligible for Medicaid.

Eligibility Determination:

Children ages zero through eighteen in families whose income is at or below 150% of the federal poverty level are eligible for CHIP if other eligibility criteria are met. Eligibility specialists for the State of Montana, Department of Public Health and Human Services, make the eligibility determination at a central location.

State employees at County Offices of Public Assistance perform the final Medicaid eligibility determination and the family continues to have the option of seeking application assistance from State employees or community advocates.

CHIP eligibility is determined within ten working days of receipt of a complete application. By the 10th working day, a letter is sent to the family that the children are eligible or ineligible for the CHIP program, or that more information is needed. If families who appear to be Medicaid-eligible give permission to forward information from the application, or the application itself when the Universal Form is used, CHIP Eligibility Specialists will do so by the 10" working day.

Families who give permission to forward information to Medicaid:

A. CHIP screens all applicants for Medicaid eligibility. If the family income and family size suggests probable eligibility for Medicaid, CHIP notifies the family in writing that the child cannot be insured by the Children's Health Insurance Plan ***(see C below).***

B. The CHIP application form and the Universal Form contain a statement that demographic information from the application or the application itself will be sent to the county public assistance office to begin the Medicaid application process for children who appear to be Medicaid eligible. Families may check a box saying that this information may not be forwarded. (Demographic information includes name, address, phone number, date and place of birth, sex, social security number, marital status, and citizenship.)

C. The application form is forwarded to the Office of Public Assistance in the county in which the applying family lives. We estimate that it takes one or two days for the Postal Service to deliver the application to the appropriate county office.

D. Upon receipt of the Medicaid application in the county office, the time clock for processing Medicaid eligibility begins. The county office contacts the family and sets up an in-person interview that is part of Montana's Medicaid eligibility process, or the family may contact the county office to begin the process. The same Medicaid eligibility process and time frames are used for these "CHIP referred" families as for all other eligibility determinations. Medicaid eligibility is routinely determined within 30 days of receipt of the application in the county office if the office receives all information necessary to make an eligibility

determination.

E. Simultaneously with the CHIP application being forwarded to the county, a letter is sent to the family. The letter tells the family: 1.) The children appear to be Medicaid-eligible and we have forwarded the application to the appropriate county public assistance office to begin the Medicaid application process (unless the family has asked us not to forward the application); **2)** The family will receive a phone call or letter from their county public assistance office to set up an interview to determine Medicaid eligibility; **3)** The family should take the full Medicaid application (which we have included with the letter) and the supporting documentation specified on the application to their interview; OR in the case where the Universal Form is used, CHIP will tell the family that their application in its entirety has been forwarded to their county office; **4)** The importance of obtaining health care coverage for children and how Medicaid can assist them; and ***5)*** A telephone number to call if they need more information.

Families who do not give permission to forward their application for Medicaid determination:
Families may check a box on the Universal Form that the application may not be forwarded to the county Public Assistance Office to begin the Medicaid application process. They will have to pro-actively take this step.

A) The CHIP program screens applicants for Medicaid eligibility. If the family income suggests probable eligibility for Medicaid, the State notifies the family in writing that the child cannot be insured by the Children's Health Insurance Plan. This ineligible letter stresses the importance of health care coverage and services for children and urges the family to allow the application to be forwarded for Medicaid determination.

B) The State contacts the family two weeks after the denial letter is issued to .inquire whether the family is willing to apply for Medicaid. As **part** of this contact, the State will again stress the importance of applying for Medicaid so that the children have health care coverage.

Families who are determined ineligible for Medicaid:
Families who have been referred by the CHIP program and who are subsequently determined ineligible for Medicaid by the county public assistance office are sent a letter denying Medicaid eligibility. Offices of Public Assistance notify CHIP staff of the Medicaid denial. The children are then enrolled in CHIP. Enrollment of these children in CHIP is subject to available funding.

Applications are mailed to CHIP directly from families or from agencies or organizations assisting the families in their application process. The following information is collected to establish eligibility:

- Family income
- Family size
- Each child's name and date of birth
- If the child has been covered by other insurance during the three-month period prior to the date of the application;
- Child's citizenship, residency status and Social Security Number (optional)
- If the child is eligible for health care benefits under the State Employee Health Plan

CHIP eligibility is denied when:

(1) The child is eligible to receive health coverage benefits under the State employees health plan;

(2) The child is covered by another creditable insurance as defined in section 2791 of the Public Health Service Act;

(3) The child is enrolled in Medicaid; or

(4) The child is not a U.S. citizen or Qualified Alien as defined under federal statute.

For all other children, the information noted above is compared with the Medicaid financial eligibility tables. If the child appears to be eligible for Medicaid, CHIP eligibility will be denied pending a denial of Medicaid eligibility. The Universal Application is forwarded to the family's county Office of Public Assistance for final Medicaid determination. If the child meets the CHIP criteria and does not appear to be eligible for Medicaid, the application form will be processed and the child is enrolled in CHIP.

CHIP performs the following functions as part of the eligibility determination process:

- Track and determine application status
- Process applications
- Determine eligibility
- Refer children not eligible to Medicaid, Special Health Services, or the Caring Program
- Assist the family in choosing an insurance plan (if applicable)
- Staff a toll-free information number families may call to receive information about CHIP coverage and eligibility issues (contracted with Montana Covering Kids grantee)
- Send annual re-enrollment notices to CHIP enrollees
- Collect enrollment fees
- Provide training and support for application and outreach sites

- Provide a grievance process for applicants who are denied CHIP eligibility
- Facilitate a smooth transition between different Children's Health Insurance Plan providers and between CHIP and Medicaid or CHIP and private insurance
- Provide eligibility data needed for annual reports

Enrollment in Health Plans:
Children's Health Insurance Plan applications will include information on insurance plans and HMOs available in different geographic locations, if applicable. Parents will be instructed to select a plan or HMO for their children and will be able to call CHIP staff or the toll-free Family Assistance Line if they have questions.

Redetermination of Eligibility:
Children enrolled in the Children's Health Insurance Plan are enrolled for twelve months unless the child's status changes (see Section 4.1.8). Proof of income upon renewal must be documented as in the initial enrollment. Renewal packets are mailed to families 45 days before the end-of-coverage date. Reminder cards are mailed 30 days before the end-of-coverage date. If the application is not returned by the end-of-coverage date, coverage will terminate. The child may reapply for coverage at a later date without a penalty. The child will not, however, be given preference for coverage; acceptance will be subject to available funding.

Enrollment Fee:
An annual enrollment fee of $15 per family is assessed for families living between 100% and 150% of poverty. No enrollment fee will be assessed for families living below 100% of poverty.

4.4 Describe the procedures that assure:

4.4.1 Through intake and follow-up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan (Section 2102(b)(3)(A))

Because Montana's Medicaid eligibility depends on age, income, and assets, each child in a family must be separately screened for possible Medicaid eligibility. If one child of several in a family is found to be eligible for Medicaid, CHIP's eligibility system will allow technicians to enroll only those children not eligible for Medicaid into the Children's Health Insurance Plan.

CHIP will not determine Medicaid eligibility. Screening for Medicaid eligibility, however, will be done by CHIP staff. If a child appears to be eligible for Medicaid, the family will be notified by letter saying the child

cannot be insured by the Children's Health Insurance Plan because the child appears to be eligible for Medicaid. The family will be informed of the benefits of Medicaid, offered assistance in completing the Medicaid application, and given a toll-free telephone number to call with questions. The family will be notified the CHIP denial will be reconsidered if parents have applied for and been denied Medicaid within the last six months. CHIP staff will accept a copy of the Medicaid denial letter or other notification from county Public Assistance Office that the children are not eligible for Medicaid.

Families who apply for Medicaid and are denied will be informed about CHIP. With a family's permission, the Children's Health Insurance Plan will receive information collected for the Medicaid application or a copy of the Universal Form submitted for Medicaid determination.

Other Creditable Coverage Screening:
The Children's Health Insurance Plan application will ask the applicant to report any health insurance coverage. If the family reports creditable coverage as defined in section **2791** of the Public Health Service Act, the child will be found ineligible for CHIP. Insurance plans and HMOs contracting with CHIP will be required contractually to notify CHIP whenever they have reason to believe a member has other coverage. CHIP staff will investigate and if the child has other creditable insurance coverage, CHIP coverage will be terminated.

4.4.2 That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan (Section 2102(b)(3)(B))

CHIP staff screens applicants for Medicaid eligibility. If income suggests probable eligibility for Medicaid and the family has given permission, their application is forwarded to their county Office of Public Assistance. The Office of Public Assistance has been asked to contact the family to schedule an interview. Children who appear to be Medicaid eligible will only be enrolled in the Children's Health Insurance Plan after they have been denied Medicaid eligibility.

4.4.3 That the insurance provided under the state child health plan does not substitute for coverage under group health plans (Section 2102(b)(3)(C))

A child will be ineligible for CHIP if he or she has been covered under a creditable individual or group health plan during the three months prior to application for CHIP. If, however, a parent who is providing the primary insurance is fired, laid off, can no longer work because of a disability, has a lapse in insurance coverage because he or she obtains new employment, the employer no longer offers dependent coverage, or the parent dies, the

three-month waiting period for the Children's Health Insurance Plan will not apply.

4.4.4 The provision of child health assistance to targeted low income children in the state who are Indians (as defined in Section 4C of the Indian Health Care Improvement act, 25 U.S.C. 1603C (Section 2102(b)(3)(D))

The Children's Health Insurance Plan works directly with tribes, urban Indians, the Indian Health Service, Tribal Health Services, and Urban Indian Centers to inform Native Americans in Montana about CHIP. Tribal chairpersons and other influential Native Americans have been contacted to begin this process. Insurance plans will be required to offer a contract to Urban Indian Centers, Indian Health and Tribal Service providers who meet certification qualifications. See Sections 3.1 and 9.9 for more information.

4.4.5 Coordination with other public and private programs providing creditable coverage for low income children (Section 2102(b)(3)(E))

Steps will be taken to ensure that coordination with private insurance coverage takes place as outlined in Section 4.4.3. CHIP will be coordinated with state Maternal Child Health and mental health programs to ensure that children with needs beyond what CHIP covers will be referred to these existing programs (examples include the program for Children with Special Health Care Needs, the Mental Health Services Plan, visiting nurses, etc.). Montana currently has no health insurance programs that are public-private partnerships providing creditable insurance coverage.

The state will continue to work for streamlined enrollment procedures and collaborative outreach efforts to further the plan's goal to coordinate with other public and private programs.

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)

Montana utilized a broad-based team to develop the State Plan. Members of this team represent schools, day care centers, managed care organizations, public and private health care providers, children's advocacy groups, Native Americans, and other stakeholders. These groups are committed to finding and helping enroll all eligible children.

Assumptions about the target population for CHIP are based on the experience of the Montana Medicaid Program, the Caring Program for Children, and social services and health care agencies and providers. For an audience consisting of families with a variety of financial needs, CHIP must appeal both to those who have regular interaction with human service agencies, and to the working poor who have traditionally avoided government programs. Outreach efforts for the Children's Health Insurance Plan, therefore, will emphasize that this is a low-cost private health insurance plan that is a collaborative effort between families and the state and federal governments to ensure children receive health care.

Outreach and Coordination Methods—Phase I:
The first phase of CHIP began in January of 1999 and served a limited number of children. Outreach for this small number of participants was targeted in the following manner. Children currently on the waiting list for the Caring Program for Children (which covers primary, preventive medical, dental, and vision services, as well as outpatient diagnostic, emergency, and surgical services) were sent applications for CHIP. Indian Health Services (IHS) maintains a database of IHS service users who are not on Medicaid or other insurance. This database was used to target uninsured Native American children. Families who have left the TANF program and children enrolled in the Mental Health Access Plan (now the Mental Health Services Plan), were targeted as well. These families received enrollment information and applications to enroll in CHIP through direct mailings. (Montana did not mail outreach material to families currently on TANF. As a result of our 1115 Welfare Reform Waiver, families who are eligible for TANF are automatically also eligible for Medicaid.)

Outreach and Coordination Methods—Phase II:
Montana's legislature met early in 1999 and appropriated the full State match for CHIP. CHIP benefits in Phase II began on October 1, 1999. CHIP outreach strategies include four strategies: 1) direct appeal to eligible families through press releases, public service announcements, and video; 2) outreach through

schools; **3)** outreach through collaboration with local agencies, grassroots organizations, and providers; and 4) outreach collaboration with statewide maternal child health organizations. Each of these strategies is further detailed below.

Direct Appeal to Eligible Families through Press Releases, Public Service Announcements, Brochures. Posters, and Video:
Radio and television public service announcements will be aired about CHIP. **A** toll-free number to call for more information will be featured in the public service announcements, printed materials, and press releases. Frequent news releases will be sent to the media about the increased insurance coverage available to children. Radio stations, TV and cable stations, Montana daily and weekly newspapers, and specialty publications and newsletters for professional associations in children's health care, parenting, day care, and education will receive the press releases and news items.

Outreach methods other than written materials will be employed whenever possible. All outreach materials will prominently feature the toll-free telephone number. Callers to the toll-free number will hear a recorded message about the plan, speak to a customer service representative, or leave their name and address to receive an application. Brochures and posters are prominently displayed in locations frequented by low-income families with children.

Outreach through Schools:
CHIP collaborates with the Office of Public Instruction to conduct mid-year and back-to-school enrollment campaigns in school districts statewide. Enrollment information and applications were sent to schools to help conduct CHIP outreach. School counselors are an important part of school-based outreach. Articles and information in school newspapers is another way to reach families.

Outreach through schools has been the most successful means employed by the Florida Healthy Kids project and Montana's Caring Program for Children. It involves relatively low costs and we believe that we can replicate the success of these two programs.

Outreach through Collaboration with Local Agencies, Grassroots Organizations, and Providers:

The Montana Department of Public Health and Human Services (DPHHS) supported the state's Robert Wood Johnson Covering Kids grantee in their grant application and continues to commit personnel and resources to the success of Covering Kids in Montana. The Covering Kids grantee supports advocates in Montana communities and has designed and implemented a state-wide media campaign to encourage families to get health-care coverage for their children through CHIP, Medicaid, or other programs for which their children may qual fy

3

DPHHS has contracted with community-based organizations and agencies in 30 additional communities to carry out outreach designed specifically for each community for CHIP and Medicaid.

Outreach training sessions on CHIP eligibility have been conducted for the staff of county public health departments, county social services, WIC coordinators, county public assistance offices, family resource centers, churches, the program for Children with Special Health Care Needs, community-centered boards of grassroots organizations, Child Care Resource and Referral agencies, tribal health and social services staff, and Head Start.

Outreach for CHIP and Medicaid will continue to be conducted through DPHHS home visiting and case management program. Home visitors give pregnant women and parents CHIP and Medicaid program information and answer questions.

CHIP also builds upon Montana Medicaid program's relationships with primary care providers and Medicaid recipients. Newsletters are sent to providers monthly and to recipients three times a year to update them on developments in the Medicaid program. Articles about CHIP are included in these mailings.

The CHIP program works with Native American leaders, both urban and reservation, to develop specific outreach activities for this population. Similarly, we work with the Montana Migrant Council to develop specific outreach activities for migrant workers statewide.

Outreach through Collaboration with Statewide Maternal Child Health Organizations:
Montana DPHHS contracts with the Montana Coalition for Healthy Mothers, Healthy Babies (HMHB) to provide comprehensive outreach, information and referral, and a public relations campaign called Montana's Child. Information about CHIP will be featured in this program. In addition, HMHB operates the Maternal Child Health toll-free hotline through a contract with DPHHS. This hotline will be used to dispense information about CHIP.

The Montana Council for Maternal and Child Health did a series of community forums where family health care issues were discussed. They prominently featured CHIP in these forums.

5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

The Children's Health Insurance Plan's outreach efforts described above will be coordinated as often as possible with Medicaid and other children's health coverage or direct services. The coordination will be facilitated by the fact that

CHIP, Title X, Title V, and Medicaid all reside in the Health Policy and Services Division of DPHHS and top management staff for the programs meet at least weekly.

Coordination efforts are described in Sections 2.3, 4.3 - 4.4.5, and 5.1

Section **6.** Coverage Requirements for Children's Health Insurance (Section **2103)**

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and continue on to Section **7.**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.)

6.1.1. ☐ Benchmark coverage; (Section **2103(a)(1))**

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section **2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section **2103(b)(2))** (If checked, identify the plan and attach **a** copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section **2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☒ Benchmark-equivalent coverage; (Section **2103(a)(2))** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section **2103(c)(4).**

The Actuarial report and supporting documentation are found in Appendix A. Background detail for the monthly insurance rate paid for each enrollee each month is found in Appendix B.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section **2103(a)(3))** [Only applicable to New York; Florida; Pennsylvania.] Please attach a description of the benefit's package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of **8/5/97** or one of the benchmark plans. Describe the fiscal year **1996** state expenditures for "existing comprehensive state-based coverage."

6.1.4. ☐ Secretary-Approved Coverage. (Section **2103(a)(4))**

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

The following statements apply to all services covered in this section (6.2):

1. There are no pre-existing condition limitations.
2. Experimental procedures, custodial care, personal comfort/hygiene/convenience items which are not primarily medical in nature, whirlpools, organ and tissue transplants, TMJ treatment, treatment for obesity, acupuncture, biofeedback, chiropractic services, elective abortions, in vitro fertilization, gamete or zygote intrafallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, fertility enhancing treatment beyond diagnosis, cosmetic surgery, radial keratotomy, private duty nursing, treatment for which another coverage such as workers compensation is responsible, routine foot care, services for members confined in criminal justice institutions, and any treatment not medically necessary are not a covered benefit. These exclusions are in addition to any exclusions noted in the individual coverage descriptions.
3. **A** $1 million lifetime maximum benefit coverage per insured person per health plan applies.

6.2.1. ☒ **Inpatient services** (Section 2110(a)(1)): Semi-private room; intensive and coronary care units; general nursing; drugs; oxygen; blood transfusions; laboratory; imaging services; physical, speech, occupational, heat, and inhalation therapy; operating, recovery, birthing and delivery rooms; routine and intensive nursery care for newborns; and other medically necessary services and supplies for treatment of injury or illness are covered.

Coverage of postpartum care for at least forty-eight hours for vaginal delivery and ninety-six hours for cesarean section is guaranteed.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.10 and 6.2.18.

Organ and tissue transplants are not covered.

6.2.2. ☒ **Outpatient services** (Section 2110(a)(2)): **All** services described in 6.2.1 which are provided on an outpatient basis in a hospital (including but not limited to observation beds and partial hospitalization services) or ambulatory surgical center; chemotherapy; emergency room services for surgery, accident or

medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, accident, or illness are covered.

Services for mental and chemical dependency disorders are outlined in Sections 6.2.11 and 6.2.19

A $5 copayment per emergency room service is applied.

6.2.3. ☐ **Physician services (Section 2110(a)(3)):** Office, clinic, home, outpatient surgical center and hospital treatment for a medical condition, accident, or illness by a physician or advanced-practice registered nurse are covered.

Well-child, well-baby, and immunization services as recommended by the American Academy of Pediatrics are covered.

Routine physicals for sports, employment, or required by a government authority are covered.

Anesthesia services rendered by a physician-anesthesiologist(other than the attending physician or assistant) or by a nurse anesthetist are covered provided that surgical and/or hospital benefits are also covered. Hypnosis, local anesthesia (unless it is included as part of a global procedure charge), and consultations prior to surgery are not covered.

6.2.4. ☐ **Surgical services (Section 2110(a)(4)):** Covered as described in 6.2.1, 6.2.2, and 6.2.3. In addition, professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

Organ and tissue transplants are not covered.

6.2.5. ☒ **Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5)):** Covered as described for other services described in this Section(6.2).

6.2.6. ☐ **Prescription drugs (Section 2110(a)(6)):** Coverage includes drugs prescribed by a practitioner acting within the scope of his or her practice. Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, and drugs needed after an organ or tissue transplant are covered.

Birth control contraceptives are not covered.

Plans may use the Medicaid formulary.

Diabetic supplies including insulin, test tape, syringes, needles, and lancets are covered as prescription drugs.

Food supplements and vitamins (with the exception of prenatal vitamins), whether or not requiring a written prescription, are not covered.

6.2.7. ☐ **Over-the-counter medications** (Section 2110(a)(7))

6.2.8. ☒ **Laboratory and radiological services** (Section 2110(a)(8)): Coverage includes imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in this section(6.2).

X-ray, radium, and radioactive isotope therapy are covered.

6.2.9. ☒ **Prenatal care and prepregnancy family planning services and supplies** (Section 2110(a)(9)): Prenatal care is covered as described for other medical conditions in this Section *(6.2)*.Prepregnancy family planning services are covered. Birth control contraceptives are not covered.

Medical or surgical treatment to reverse surgically induced infertility; fertility enhancing procedures beyond diagnosis; and sex change operations are excluded.

6.2.10. ☒ **Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services** (Section 2110(a)(10)): CHIP covers up to twenty-one days of combined mental health/chemical dependency benefits per benefit year. Partial hospitalization services may be exchanged for inpatient days at a rate of one inpatient day for two partial treatment days. A partial hospitalization program that is operated by a hospital must comply with the standards for a partial hospitalization program that are published by the American Association for Partial Hospitalization.

CHIP enrollees who have mental health needs beyond the coverage provided by CHIP and who have been diagnosed as seriously emotionally disturbed will be eligible for Montana's Mental Health Services Plan (MHSP). MHSP is a comprehensive program that

provides mental health care to Montana children who are seriously emotionally disturbed. MHSP has no coverage limits beyond medical necessity.

CHIP enrollees with the following disorders are not subject to a limit on covered inpatient mental health benefits provided by CHIP: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

6.2.11. ☒ **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11):**

Outpatient mental health services are coordinated between CHIP and the Mental Health Services Plan. CHIP enrollees who have mental health needs beyond the coverage provided by CHIP and who have been diagnosed as seriously emotionally disturbed will be eligible for Montana's Mental Health Services Plan (MHSP). MHSP is a comprehensive program that provides mental health care to Montana children who are seriously emotionally disturbed. MHSP has no coverage limits beyond medical necessity.

Professional outpatient services up to a maximum of twenty visits per year will be paid through the insurance plan. Partial hospitalization services are paid as described in section **6.2.10.** Children who are enrolled in CHIP and MHSP and need services beyond those CHIP provides may obtain those services from MHSP.

CHIP enrollees with the following disorders are not subject to a limit on covered inpatient mental health benefits provided by CHIP: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, and autism.

6.2.12. ☐ **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))**

6.2.13. ☐ **Disposable medical supplies (Section 2110(a)(13))**

6.2.14. ☐ **Home and community-based health care services (See instructions) (Section 2110(a)(14))**

6.2.15. ☐ **Nursing care services (See instructions)** **(Section 2110(a)(15))**

6.2.16. ☒ **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest** **(Section 2110(a)(16):**

6.2.17. ☒ **Dental services** **(Section 2110(a)(17))**
Each CHIP enrollee is eligible to receive $200 in dental services each benefit year (October 1 through September 30). CHIP dental services are not included in the benefits provided by the insurance plan. Dental services are provided by the State of Montana, Department of Public Health and Human Services, on a fee-for-service basis.

6.2.18. ☒ **Inpatient substance abuse treatment services and residential substance abuse treatment services** **(Section 2110(a)(18))**: The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a minimum benefit of $6000 in a 12-month period, until a lifetime impatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

6.2.19. ☒ **Outpatient substance abuse treatment services** **(Section 2110(a)(19))**: The combined benefit for inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a minimum benefit of $6000 in a 12-month period, until a lifetime impatient maximum benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000. Costs for medical detoxification treatment are paid the same as any other illness and are not subject to the lifetime limits.

6.2.20. ☐ **Case management services** **(Section 2110(a)(20))**

6.2.21. ☐ **Care coordination services** **(Section 2110(a)(21))**

6.2.22. ☐ **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders** **(Section 2110(a)(22))**

6.2.23. ☐ **Hospice care** **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. **(See instructions)** **(Section 2110(a)(24)):**
Vision Services and Medical Eye Care—Services for the medical treatment of diseases or injury to the eye by a licensed physician or optometrist working within the scope of his or her license are covered. Vision exams and eyeglass dispensing fees are covered.

Corrective lenses are provided by the State of Montana, Department of Public Health and Human Services. Corrective lenses are not covered by the insurance plan.

Audiological Services—Hearing exams, including newborn hearing screens in a hospital or outpatient setting, are covered. Coverage includes assessment and diagnosis. Hearing aides are not covered.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☐ Medical transportation **(Section 2110(a)(26))**

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3. Waivers - Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: **(Section 2105(c)(2) and (3))**

6.3.1. ☐ Cost Effective Alternatives. Payment may be made to a state in excess of the **10%** limitation on use of funds for payments for: 1)other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the pian; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above. Describe the coverage provided by the alternative delivery system. The state may cross reference section **6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(I))**

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and describe the cost of such coverage on an average per child basis. **(Section 2105(c)(2)(B)(ii))**

6.3.1.3. The coverage must be provided through the use of **a** community-based health delivery system, such as through contracts with health centers receiving funds under section **330** of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section **1886(d)(5)(F)** or **1923** of the Social Security Act. Describe the community based delivery system. **(Section 2105(c)(2)(B)(iii))**

6.3.2. ☐ Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3))**

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) **(Section 2105(c)(3)(A))**

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B))**

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☒ Performance measurement
7.1.3. ☒ Information strategies
7.1.4. ☐ Quality improvement strategies

Only **23,130** of the state's insured population are served through a Health Maintenance Organization (HMO). No Montana HMO is accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditations of Healthcare Organizations (JCAHO) or any other national accreditation body. The low penetration rate for managed care, our sparse population, and lack of national accreditation for our HMOs necessitate that Montana choose quality and appropriateness standards applicable to both HMO and indemnity insurance plans. Medicaid and CHIP management staff are also interested in assuring continuity and comparability between the measures we use in the two programs. Medicaid currently uses HEDIS measures for both its Primary Care Case Management Program (PASSPORT) and its HMO program. For these reasons, CHIP will use HEDIS performance measurements to evaluate effectiveness of care for CHIP enrollees.

Contracts with insurance plans require the plans to collect and report HEDIS data. The following is a list of required measures:

HEDIS **3.0**

- Childhood immunization status
- Adolescent immunization status
- Children's access to primary care providers
- Well-child visits in the first fifteen months of life
- Well-child visits in the third, fourth, fifth, and sixth year of life
- Adolescent well care visits

CHIP will use these performance measures—HEDIS and complaint data—to annually evaluate a health plan's performance and to provide information to assist enrollees in choosing a plan. While HEDIS measures are an important component

of the CHIP quality program, the data will not be available until after a full year of plan operation. Until then the program will rely on reported complaints to monitor quality of care.

Consumer education tools were developed to ensure CHIP enrollees have adequate information to negotiate plan enrollment. A plan member handbook was developed by the plans and reviewed and approved by state CHIP staff to assure that benefit, provider network, and grievance procedures are communicated effectively. Other consumer education materials are being developed as part of CHIP's quality assurance program and will be based on results of performance measures.

7.2 Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

Access Assurance for Care Delivered through Insurers and the CHIP Provider Network:

Access to services is measured by evaluating and monitoring the adequacy of provider networks and by analyzing the results of complaint data and performance measures. Provider network analysis looks at the number and types of physicians and non-physician providers of health care for children, their locations, and their hours. For HMOs, the primary data source for this evaluation will be the HMO's Network Access Plan. The Department of Public Health and Human Services (DPHHS) is responsible for monitoring HMO network adequacy under state law. An HMO's access plan details its provider network including numbers, types, locations, referrals, and accommodation of members with special needs, e.g., physically accessible facilities. Indemnity insurance providers will be required to produce a similar access plan for CHIP. DPHHS staff will evaluate this network as described in Section **3.1.** CHIP staff will also annually evaluate access-related performance measures such as access-related complaints and access to primary care physicians (HEDIS).

Emergency Services Access:

Contracts with insurance plans specify that insurance plans may not require prior authorization for emergency medical conditions. An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses **an** average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the child (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Access to emergency services will be monitored by analysis of complaint data.

Section **8.** Cost Sharing and Payment (Section 2103(e))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. ☒ **YES**
8.1.2. ☐ **NO,** skip to question **8.5.**

8.2. Describe the amount of cost-sharing and any sliding scale based on income: **(Section 2103(e)(1)(A))**

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance:
8.2.4. Other:

Annual Enrollment Fee:

A) No annual enrollment fee will be assessed for families belov 100% of the federal poverty level.

B) **A** $12 annual enrollment fee will be charged for a family of one who is at or above 100% of the federal poverty level. This would apply only in the case of an emancipated minor, since all families with a parent present will have at least two members.

C) **A** $15 annual enrollment fee will be charged for families of two or more who are at or above 100%.of the federal poverty level.

Co-payment:

A) No co-payment will be assessed for families below 100% of the federal poverty level.

B) For families at or above 100% of the federal poverty level, the following co-payments will apply:

Benefit	Copayment
Inpatient hospital services (includes hospitalization for physical, mental and substance abuse reasons)	$25 per visit
Emergency room visit	$5 per visit
Outpatient hospital visit (includes outpatient treatment for physical, mental, and substance abuse reasons. Excludes outpatient visits for X-ray or laboratory services only)	$5 per visit
Physician, mid-level practitioner, advanced practice registered nurse,	$3 per visit

optometrist, audiologist, mental health professional, or substance abuse counselor services (excludes pathologist, radiologist, or	
Outpatient prescription drugs—generic	$3 per prescription
Outpatient prescription drugs—brand-name	$5 per prescription

The insurance card each child receives from his or her insurance plan indicates whether or not a child has a copayment when services are used. When a family is required to make copayments when services are used, the insurance accumulates the copayments charged to the family. When the $200 annual family maximum is reached, the insurance plan sends each child in the family a new card indicating that a copayment is not required.

If a family is charged more than the $200 copayment cap, the family submits to CHIP receipts for copayment amounts they have paid. The State will reimburse the family for the amount equal to their excess payment.

Families are notified through CHIP enrollment materials of the process to recoup any excess copayments they have paid.

Families with income less than 100% of poverty have no copayment requirement and have an insurance card for each child that clearly states that no copayment is required when the child receives services.

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

A description of the annual enrollment fee and copayment will be contained in the application, the outreach materials and educational materials distributed for CHIP.

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. ☒ No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. ☐ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. ☐ No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A))**

8.4.7. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June **1,1997.** **(Section 2105(d)(1))**

8.4.8. ☒ **No** funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))**

8.4.9. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except **as** described above). **(Section 2105)(c)(7)(A))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed ***5*** percent of such family's annual income for the year involved **(Section 2103(e)(3)(B))**: This section is not applicable since Montana will not serve families above 150% of the federal poverty level. Our enrollment fee falls under the cost-sharing guidelines for the Medicaid program as required by section 2103(e)(3)(A).

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii)); OR**

8.6.2. ☐ The state contracts with a group.health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section **6.3.2.** of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2)).** Please describe:

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1 Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:

Montana's strategic objectives are to:

1. Improve the health status of children covered by CHIP with a focus on preventive and early primary treatment.
2. Increase the proportion of children who are insured and reduce the financial barriers to affordable health care coverage.
3. Prevent "crowd out" of employer coverage.
4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
5. Increase the enrollment of currently eligible, but not participating, children in the Medicaid program.

9.2 Specify one or more performance goals for each strategic objective identified:

Because Montana did not have a children's health insurance program prior to 1999 and funding constraints limited our first year efforts, all performance goals noted below are targets for State Fiscal Year 2001 unless otherwise noted.

1. Improve health status of children covered by the CHIP program with a focus on preventive and early primary treatment.
   Performance goals:
   - Establish a baseline for enrolled children under two years of age who receive the basic immunization series.
   - Establish a baseline for enrolled thirteen-year-olds who receive required immunizations.
   - Establish a baseline for enrolled children under fifteen months who receive recommended number of well child visits.
   - Establish a baseline for enrolled three, four, five and six-year-old children who receive at least one well-child visit during the year.
   - Establish a baseline for enrolled children twelve through seventeen who receive at least one well-care visit during the year.

2. Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage.
   Performance goal:
   - Decrease the number of children ≤ 150% of federal poverty level who are uninsured.

3. Prevent "crowd out" of employer coverage.
Performance Goal:
- Maintain the proportion of children ≤ 150% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy.

4. Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children.
Performance Goals:
- Enroll **80%** of children on the waiting list for the Caring Program for Children in the Children's Health Insurance Program.
- Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid.
- Co-ordinate with the Title V Children With Special Health Care Needs and the Mental Health Access programs to ensure that children who need care beyond what is offered under CHIP are referred to these programs.
- Enroll 50% of the children served by the Children With Special Health Care Needs program who are also eligible for CHIP in CHIP.
- Enroll 90% of children in the Mental Health Services Plan who are also eligible for CHIP in CHIP.

5. Increase the enrollment of currently eligible, but not participating, children in the Medicaid program.
Performance goals:
- Ensure that 50% of children referred from CHIP to Medicaid enroll in Medicaid.

9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

Objective One: Improve health status of children covered by CHIP with a focus on preventive and early primary treatment: Insurance plans and HMOs will be required to collect and report HEDIS data. The Department of Public Health and Human Services will use this data to measure success of the plans in establishing baseline data and reaching the performance goals regarding immunization and well-child care.

Objective Two: Decrease the proportion of children in Montana who are uninsured and reduce financial barriers to affordable health care coverage:

Performance goals under this objective will be measured based on the decrease in the number of children in families with incomes ≤150% of the federal poverty level who are uninsured compared with the number that were uninsured before the effective date of this state plan. Two different measures will be used to determine the number of uninsured children. First, baseline numbers of uninsured children will be calculated *fiom* a three-year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey produced by the Bureau of the Census. New estimates of uninsured children will be calculated as more current data become available and will be used to compare trends from year to year. Second, questions will be added to the Behavioral **Risk** Factor Surveillance System (BRFSS) to establish both baseline information and **an** ongoing assessment of the insurance status of Montana youth. This data will be used to supplement the census data.

Enrollees who leave CHIP before their twelve months of eligibility have expired and those who fail to re-enroll will be surveyed to learn why they are no longer enrolled in CHIP. Responses will be tracked and used to evaluate the extent that CHIP has reduced financial barriers to affordable health care coverage.

Objective Three: Prevent "crowd out" of employer coverage: Performance goals under this objective will be measured based on the proportion of children ≤ 150% of federal poverty who are covered under an employer-based plan taking into account decreases due to increasing health care costs or a downturn in the economy. The proportion of children covered under an employer-based plan will be evaluated, and analysis will be conducted to test for evidence of "crowd out." The baseline for comparison will be obtained fiom a 3-year average of the 1995, 1996, and 1997 March supplement to the Current Population Survey. Questions will be added to the Behavioral Risk Factor Surveillance System (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status for Montana youth. This latter data will be used to supplement the census data.

In addition, the eligibility determination process includes questions relating to parents' access to and coverage by health insurance. This allows the state to track the number of children who have access to employment-based coverage and to ensure that children enrolling in CHIP are uninsured and are not dropping their employment-based coverage to enroll in CHIP.

Objective Four: Coordinate and consolidate with other health care programs providing services to children to create a seamless health care delivery system for low-income children: Performance goals under this objective will be based on the enrollment of children previously receiving care through the Caring Program for Children, the Mental Health Services Plan, and Medicaid. Clients who enroll in CHIP aare tracked in an eligibility system that interfaces with the Medicaid Management Information System allowing for coordination with Medicaid. The CHIP eligibility system also performs Medicaid screening and allows the state to

track the number of children who were referred to Medicaid through the eligibility determination process. CHIP will query Medicaid enrollment data to learn how many children referred from CHIP to Medicaid have enrolled. CHIP will also query the Mental Health Services Plan to find whether children are enrolled in both programs. Coordination with the administrator of the Caring Program will provide information about numbers of children enrolled in CHIP who were previously on the waiting list for the Caring Program.

Objective Five: Increase the enrollment of currently eligible, but not participating., children in the Medicaid program: Children who enroll in CHIP are'tracked in an eligibility system that interfaces with the Medicaid Management Information System allowing for coordination with Medicaid. The CHIP eligibility system also conducts Medicaid screening and will allow the state to track the number of children who were referred to Medicaid through the eligibility determination process. CHIP will query Medicaid enrollment data to determine how many children referred from CHIP to Medicaid have enrolled.

Check the applicable suggested performance measurements listed below that the state plans to use:

9.3.3 ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2 ☒ The reduction in the percentage of uninsured children.

9.3.3 ☐ The increase in the percentage of children with a usual source of care.

9.3.4 ☐ The extent to which outcome measures show progress on one or more of the health problems identified **by** the state.

9.3.5 ☐ HEDIS Measurement Set relevant to children and adolescents younger than **19.**

9.3.6 ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7 ☒ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1 ☒ Immunizations

9.3.7.2 ☒ Well child care

9.3.7.3 ☐ Adolescent well visits

9.3.7.4 ☐ Satisfaction with care

9.3.7.5 ☐ Mental health

9.3.7.6 ☐ Dental care

9.3.7.7 El Other, please list: Children's access to primary care providers.

9.3.7.8 ☐ Performance measures for special targeted population

9.4 El The state assures it will collect all data, maintain records and furnish reports to the Secretary (clarify the Secretary) at the times and in the standardized format that the Secretary requires.

9.5 ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10.1 and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports.

The Montana Department of Public Health and Human Services will do the annual assessments and evaluations required in Section 2108(a). The Annual Report will include an assessment of the operation of the Children's Health Insurance Plan, its progress toward meeting its strategic objectives and performance goals. The baseline number of uninsured children will be calculated from an average of the 1995, 1996, and 1997 March supplements to the Current Population Survey produced by the Bureau of the Census. Questions will also be added to the Behavioral Risk Factor Surveillance System (BRFSS) to establish both baseline information and an ongoing assessment of the insurance status for Montana youth. This data will be used to supplement the census data.

By March 31, 2000, the state will submit an evaluation as specified in Section 2108(b) using the Evaluation Framework developed by the National Academy for State Health Policy and approved by HCFA. The evaluation will include the following elements:

A. An assessment of the effectiveness of CHIP in increasing the number of children with creditable health coverage.

B. An assessment of the effectiveness of other public and private programs in Montana.

C. **A** description and analysis of:

- Characteristics of children and families
- Access to or coverage by other health insurance prior to and after eligibility
- Serviceare
- Time limits for coverage
- Quality
- Sources of non-Federal funding

D. State activities to coordinate CHIP with other programs

E. Analysis of trends that affect access, affordability and quality of health care to children

F. Description of plans for improving availability of coverage

G. Recommendations for improving CHIP

9.6. ☐ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3))**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title **XXI,** to the same extent they apply to a state under Title **XIX: (Section 2107(e))**

9.8.1. ☐ Section **1902(a)(4)(C)** (relating to conflict of interest standards)
9.8.2. ☐ Paragraphs **(2), (16)** and **(17)** of Section **1903(I)** (relating to limitations on payment)
9.8.3. ☐ Section **1903(w)** (relating to limitations on provider donations and taxes)
9.8.4. ☐ Section **1115** (relating to waiver authority)
9.8.5. ☐ Section **1116** (relating to administrative and judicial review), but only insofar as consistent with Title **XXI**
9.8.6. ☐ Section **1124** (relating to disclosure of ownership and related information)
9.8.7. ☐ Section **1126** (relating to disclosure of information about certain convicted individuals)
9.8.8. ☐ Section **1128A** (relating to civil monetary penalties)
9.8.9. ☐ Section **1128B(d)** (relating to criminal penalties for certain additional charges)

9.8.10. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. ***(Section 2107(c))***

Public involvement and support are essential if we are to make CHIP a successful program in Montana. To ensure that we obtain support, the state has held numerous discussions and meetings with key stakeholders in Montana. The primary means we used are outlined below:

CHIP Advisory Committee:
The Department of Public Health and Human Services (DPHHS) hosted a preliminary meeting on 7/31/97 to discuss a planning strategy for the CHIP program with children's advocacy groups, the Governor's budget staff, Title X, Medicaid, and health insurers. DPHHS then formed a broad-based Children's Health Insurance Advisory Committee to develop the plan for implementing the block grant. The Advisory Committee includes representatives from the Governor's office, DPHHS (Title X, Title V, Medicaid Part C, TANF), State Insurance Commissioner's Office, Office of Public Instruction, members of the State Legislature, children's advocacy groups, families, schools, clergy, business, insurance, health care providers, Native Americans, and others. The Advisory Council met four times (9/22/97, 10/20/97, 1/27/98, and 3/31/98). The meetings were open to the public. They were advertised in the newspapers and on the Department bulletin board and were well-attended (80 to 130 people in attendance at each meeting). The last two meetings used the state's interactive video technology; people from eight different communities were able to participate.

Basic design of CHIP including using Medicaid, private insurance, or a combination for coverage; insurance benefit design; and cost-sharing options were discussed thoroughly. All comments and suggestions were given serious consideration in developing the state plan. The "draft)' state plan itself was the topic of the 3/31/98 meeting.

Since the implementation of CHIP, DPHHS advisory councils already in place have provided important advice, comments, and recommendations to CHIP. CHIP staff sit on the advisory council for Covering Kids.

Public Forums:
In late November and early December of 1997, public forums were held in Miles City, Billings, Great Falls, Missoula, Kalispell, and Bozeman to gather public opinion about the design of the CHIP program. Invitations were sent to more than 1020 people/organizations (including Head Starts, tribal chairs, county public assistance directors, legislators, county commissioners, Human Resource Development Councils, family preservation groups, the DPHHS Native American

Advisory Council, Medicaid Primary Care Providers, provider and consumer associations, Montana Health Care Coalition, Montana Health Care Advisory Council and low income advocacy groups).

The forums were held in the evening to ensure maximum participation. More than 120 people attended the forums. Fifty of those attending signed in as citizens, taxpayers, or members of low income advocacy coalitions. An overview of the program was given and people were specifically asked their thoughts on coverage (Medicaid, private insurance, or a combination), components of the benefit package, and cost-sharing.

Native Americans:
Presentations on the proposed components of the CHIP package were made to Native Americans in three different forums. These include the Region VIII HCFA Tribal Consultation meeting 11/6/97, the Montana-Wyoming Area Indian Health Board meeting on 11/24/97, and the DPHHS Native American Advisory Council meeting 12/9/97. Again, an overview **of** the program was given and people were specifically asked their thoughts on coverage (Medicaid, private insurance, or a combination), components **of** the benefit package, and cost-sharing. Each audience was asked about their ideas for outreach to Native American populations.

Legislative Input:
The Department made presentations at ten interim committee meetings on the CHIP program between October 1997 and March 1998. These included the Legislative Finance Committee, the Oversight Committee on Children and Families, and the Committee on Indian Affairs. In addition, all legislators received three newsletters containing CHIP program development updates and an invitation to attend the public forums. Four key legislators serve on the CHIP Advisory Council.

Numerous presentations were made to Legislative Committees during the biannual session that met January through April of 1999. The Legislature created CHIP with Senate Bill **8**1. The CHIP legislation received broad bipartisan support. The State's share of CHIP funding was provided by Montana's share of the Tobacco Settlement.

Meetings With Interested Parties:
CHIP staff have given more than ninety presentations to other interested parties. Some of the groups we met with are: Montana Hospital Association, Montana Health Coalition, Health Advisory Council, statewide Public Health Association conference, Family Planning State Council, Montana Council for Maternal and Child Health, Montana Children's Alliance, Children's Committee of the Mental Health Association, Head Start, statewide meeting of Public Health and School Nurses, Governor's Council on Children and Families, the Montana Association of Counties Human Services Committee, Montana People's Action, Working for

Equality and Economic Liberation, Montana Covering Kids, and the Native American Advisory Council. At the request of several of these organizations. a CHIP update is done at each meeting, allowing time for questions, comments, and problem-solving.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

ADMINISTRATIVE COSTS (INCLUDES MARKETING AND OUTREACH)

CHILD HEALTH INSURANCE PLAN			
I. Personnel	FY 00	FY 01	FY 02
Program administration	$260,000	$260,000	$260,000
II. Other Direct Costs			
General operations	$50,000	50,000	50,000
III. Indirect Costs	$50,000	50,000	50,000
IV. Equipment and Computer Systems			
Office equipment	$5,000	$5,000	$6,000
MMIS modifications	100,000	100,000	100,000
Personal computers	9,000	9,000	9,000
V. Contract Agreements			
Data analysis and systems	$50,000	$50,000	$50,000
Marketing	$20,000	$20,000	$20,000
Total	$544,000	$544,000	$544,000

I. Personnel

Eight positions administer CHIP: A CHIP director, a program officer (1/2 FTE), an outreach coordinator, a quality assurance monitor (1/2 FTE), an eligibility supervisor, three eligibility specialists, and a program assistant.

The CHIP director manages the CHIP section. Primary duties include program development and assessment, development of policies and procedures, coordination within DPHHS and communities; personnel management, and fiscal management.

The program officer is responsible for contract management and program evaluation.

The outreach coordinator manages outreach contracts and coordinates state-wide outreach activities.

The quality assurance monitor conducts network adequacy review of the insurance plans and HMOs and monitors the performance measurements specified in the state plan.. The other half of this position is the quality assurance monitor for the Medicaid Passport to Health and HMO services. The quality assurance monitor will also assist in preparing the evaluation to be submitted by March 2000.

The eligibility supervisor manages the eligibility and enrollment unit, ensuring that applications are screened, enrollment is accomplished efficiently and effectively, and customer service provided by the unit is timely and respectful. This position is responsible for monitoring CHIP enrollment to be sure plan enrollment stays within financial allotments. This position coordinates and transfers enrollment to the insurance plans and monitors the eligibility and screening system for CHIP, coordinating with other systems as necessary. This position develops policies and procedures for eligibility and enrollment and performs training of eligibility specialists and family advocates.

The eligibility specialists receive applications and screen and enter the information into the eligibility and enrollment system. They communicate orally and in writing with CHIP applicants. These positions are responsible for delivering excellent customer service to CHIP enrollees, families, and others.

The program specialist is responsible for day-to-day management of the office functions of the CHIP section and assists the CHIP director, program officer, and outreach coordinator as needed.

11. Direct Costs

General Operations: Operating costs include equipment maintenance and repair, travel, office supplies, postage, printing, telephone maintenance, and toll charges.

111. Indirect Costs

Charges for indirect costs are estimated based on past experience with the Department's approved indirect cost allocation system. Indirect costs include personnel, space, computer linking, maintenance, fiscal and other related charges that will be associated with the CHIP program but that cannot be directly charged to the program.

IV. Equipment and Computer Systems

Office Equipment: Equipment such as photo copy and fax equipment, desks, chairs, file cabinets, etc. for CHIP program staff.

Modifications to the Medicaid Management Information System (MMIS), Eligibility System (TEAMS). and Decision Support Systems: The Medicaid MMIS has been expanded so it can make premium payments and track encounter data. Links were established with the TEAMS system to prevent duplication and ensure appropriate enrollment of individuals into either CHIP or Medicaid. A data warehouse will be established for CHIP data so it can be accessed through the existing Medicaid Decision Support System. This also includes development and enhancements to the CHIP eligibility system.

Personal Computers: Personal computers and printers for CHIP staff at a cost of approximately $30,000.

V. Contractual Agreements

Evaluation: The Department will add questions about children's insurance status to the Behavioral Risk Factor Surveillance System (BRFSS) to establish a baseline for and monitor on an ongoing basis the number of uninsured children in the state. The annual cost of obtaining data through BRFSS is $8000. We assume that any audits of the CHIP program will be performed by the Legislative Auditor's Office as part of their single audit responsibilities for the Department.

Marketing Consultants: Consultants designed a logo and images that will be associated with CHIP, and develop and print brochures, posters, and applications.

Data Analysis and Systems: CHIP contracts with the DPHHS fiscal agent to provide payments to insurance plans, claims processing and payment, compilation of encounter and claim data, and provider relations support for CHIP.

	Average Monthly Enrollment	Monthly Capita cost	Total Cost
SFY 2000			
Infants	**593**	**$101.42**	**$721,705**
1-5 year olds	**2154**	**$101.42**	**$2,621,504**
6-12 year olds	**2962**	**$101.42**	**$3,604,872**
13-18 year olds	**4391**	**$101.42**	**$5,344,023**
Total SFY 2000	**10,100**		**$12,292,104**
SFY 2001			
Infants	593	$101.42	$721,705
1-5 year olds	2154	$101.42	$2,621,504
6-12 year olds	2962	$101.42	$3,604,872
13-18 year olds	4391	$101.42	$5,344,023
Total SFY 2001	**10,100**		**$12,292,104**
SFY 2002			
Infants	593	$101.42	$721,705
1-5 year olds	2154	$101.42	$2,621,504
6-12 year olds	2962	$101.42	$3,604,872
13-18 year olds	4391	$101.42	$5,344,023
Total SFY 2002	**10,100**		**$12,292,104**

Background detail for the insurance rate paid per member per month is found in Appendix B. The monthly premium of $100.88 was added to a $.54 per month per child cost to provide the dispensing fee for the eyeglass benefit, for a total premium of $101.42. We estimate we will collect $292,205 from enrollment fees annually. This budget reflects expenditures after this amount has been removed. The $292,205 was not matched with federal funds.

CHILD HEALTH INSURANCE PLAN			
	SFY 2000	**SFY 2001**	**SFY 2002**
CHIP State Appropriation — Tobacco Settlement	$2,560,000	$2,560,000	$2,560,000
Total State Funding	**$2,560,000**	**$2,560,000**	**$2,560,000**

CHILD HEALTH INSURANCE PLAN **SUMMARY BUDGET SFY 2000-2002**				
	Total	**Matchable Expenditures**	**State Match**	**Federal Match**
Administrative Costs	544,000	544,000	108,800	652,800
Benefit Costs	12,292,104	12,292,104	2,458,420	9,833,684
Total	**$12.836.104**	**$12.836.104**	**$2.567.220**	**$10.486.484**
Administrative costs	544,000	544,000	108,800	652,800
Benefit costs	12,292,104	12,292,104	2,458,420	9,833,684
Total	**$12,836,104**	**$12,836,104**	**$2,567,220**	**$10,486,484**
Administrative costs	544,000	544,000	108,800	435,200
Benefit costs	12,292,104	12.292.104	2.458.420	9,833,684
Total	**$12,836,104**	**$12,836,104**	**$2,567,220**	**$10,268,884**

Section **10.** Annual Reports and Evaluations **(Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2))**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2 ☐ Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2 ☒ State Evaluations. The state assures that by March 31,2000, it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1 ☐ An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. ☐ The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. ☐ The quality of health coverage provided including the types of benefits provided;

10.2.2.3. ☒ The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. ☒ The service area of the state plan;

10.2.2.5. ☐ The time limits for coverage of a child under the state plan;

10.2.2.6. ☐ The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. ☒ The sources of non-Federal funding used in the state plan.

10.2.3. ☐ An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. ☒ A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

10.2.5. ☒ An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. ☒ A description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. ☒ Recommendations for improving the program under this Title.

10.2.8. ☒ Any other matters the state and the Secretary consider appropriate.

10.3 ☒ The state assures it will comply with future reporting requirements as they are developed.

10.4. ☒ The state assures it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

STATE AUDITOR
STATE OF MONTANA

Mark O'Keefe
STATE AUDITOR

COMMISSIONER OF INSURANC
COMMISSIONER OF SECURITIE

ACTUARIAL MEMORANDUM

Actuarial Opinion Regarding the Actuarial Value of the Montana Children's Health Insurance Program

I, Margaret A. Miksch, am an Associate of the Society of Actuaries and a member of the American *Academy* of Actuaries, and I meet the Academy's qualification standards for actuarial opinions related to health insurance premium rates, rating methodologies, and cost analyses. I am employed as a life and health actuary at the Montana Insurance Department. At the request of the Montana Department of Public Health and Human Services (DPHHS), I have determined the actuarial value of coverage of the benchmark benefit package and of coverage of the Montana Children's Health Insurance Program *(CHIP).* I have concluded that the CHIP meets the requirements of Title XXI of the Social Security Act with respect to its actuarial value. In the following memorandum, I will outline the methods used in my determination.

The actuarial value of the benchmark plan is based on the utilization and price factors from the Tillinghast-Towers Perrin 1998 Medical Manual and from the Tillinghast *1998* Medical and Dental HealthMAPS Health Rating Software which accompanied *the* manual, as well as on some price factors from the Montana section of the Tillinghast-Towers Pemn 1998 State Mandated Benefits Manual. The CHIP plan is valued as a HMO plan. based on utilization assumptions and price factors from the two above-referenced manuals and fiom the Tillinghast HealthMAPS 1998 PMPM program which also accompanied the manual. Attached are Exhibits I through XVII which detail the calculation of the actuarial values of the benchmark plan and of the *CHIP* plan.

The health insurance plan chosen as the benchmark plan is the Basic Pian offered to employees of the State of Montana. Accompanying this memorandum, and labeled Attachment 1, is a copy of a *summary* description of the employee health plan options, titled "Employee Medical Plans." The middle column of the "General Benefit Description" section and the left column of the "Specific Benefit Description" section provide the details of the benefits provided by the Basic Plan. The plan offers different levels of benefits based on whether the insured utilizes in-network or out-of-network providers, and also offers different outpatient mental health and chemicai dependency benefits depending on whether or not the insured was referred by an Employee Assistance Program (EAP) counselor. (For the purpose of valuing the benchmark plan for a standardized population that is representative of privately insured children, the EAP counselor will be referred to in this memorandum as a counselor from a mental health managed care company specified by the plan). Four different HealthMAPS programs were run to obtain pricing assumptions for: (1) exclusively in-network utilization & the counselor referral for outpatient mental health and chemical dependency; (2) exclusively in-network Utilization without the counselor referral for outpatient mental health and chemical dependency. (3) exclusively out-of-nenvork utilization with the counselor referral for outpatient mental health and chemical dependency; and (4) exclusively out-of-nerwork utilization without the counselor referral tor outpatient mental health and chemical dependency

The Tillinghast Medical Manual assigns the entire state of Montana to Medical Area B; this is the medical area chosen in attached Exhibits I and II, the HealthMAPS "In-Network Monthly Costs" output exhibits,

Mitchell Building/PO Box 4009/Helena, Montana 59604-4009/(406) 444-2040/1-800-332-6148/FAX (406) 444-3497

which differ only in the mental health and chemical dependency costs referred to in (1) and (2) in the above paragraph. Exhibits III and IV show the out-of-network monthly costs for Medical Area A, and differ only in the mental health and chemical dependency costs described in (3) and (4) above. Area A was chosen to approximate the 10% reduction in allowable charges covered by the State Basic Plan for services of out-of-network providers, as provided by Section K of the Medical Plan Benefits section of the Employee Benefits Plan booklet. A copy of Section K is included as Attachment 2.

The HealthMAPS program was run to obtain cost assumptions rather than the final actuarial value. *Only* the costs shown in the "children" column are meaningful. The table below explains, line by line, the rational behind the input values. The program calculates the results *in* the columns and, in a few cases, the dollar amount in the input column.

Description	Input	Explanation
1. Base Cost:	No entry	The program automatically inputs the base cost which the Medical Manual assigns to the deductible amount, assuming 80% coinsurance after satisfaction of the deductible.
Deductible:		
2. Calendar Year Deductible:	$750	The benchmark plan's annual deductible
3. Deductible Accumulation Period	12 (months)	The benchmark plan's specification
4. Eliminate Carry-Forward	Yes	The benchmark plan's specification
5. Deductibles Per Family	4.00	The plan provides for a $1,500 family deductible, roughly equivalent to the individual deductible being satisfied by two insureds. The HealthMAPS program makes adjustments only to the children rate, since the children rates assume that most of the deductible will apply to the parents' coverage. Since this is child-only coverage, setting the stoploss maximum per family at 4 is equivalent to satisfaction of the individual deductible by two children.
6. Hospital Deductible per Admission	$0	No per-admission deductible
7. Waive Deductible for Surgery	No entry	No deductible waiver for surgery
Policy Specification:		
8. In-Full Surgical Units	0.00	Cost-sharing applies immediately to surgical costs
9. In-Full Hospital Amount	$0	Cost-sharing applies immediately to hospital costs
10. ICU Maximum	Unlimited	No specified ICU maximum

Description	Input	Explanation
Covered Level:		
11. Room and Board	Use area defaults	HealthMAPS's area default approximates the actual average room and board costs in Montana
12. surgical	Use area defaults	HealthMAPS's area default approximates the actual average surgical costs in Montana
13. Adjusted Base Cost	No entry	Sum of *the* costs and cost adjustments produced by the input entries
13a. PPO Discount Value	0	The in-network and out-of-network values will be calculated by using Area *B costs* for *the* former and Area A costs for the latter
Coinsurance - General:		
14. First Coinsurance Percentage	75%	The benchmark plan's coinsurancepercentage *after* the deductible
15. on first $X after deductible	$5,000	The benchmark plan's coinsurance stoploss limit
16. Second *Coinsurance* Percentage	100%	The plan pays 100% *after* the deductible and coinsurance requirements have been met
17. on next $Y incurred	$0	A $0 entry in the dialog box indicates that the Second Coinsurance Percentage applies up to *the* lifetime maximum
18. Third Coinsurance Percentage	0%	Not applicable to the benchmark plan
19. Stop-Loss Max per Family.	3	The plan provides for a $10,000 family stoploss, roughly equivalent to the individual coinsurance limit being satisfied by two insureds. The HealthMAPS program makes adjustments *only* to the children rate, since the children rates assume that most of the coinsurance will apply to the parents' coverage. *Since this* is child-only coverage, setting the stoploss maximum per family at 3 is equivalent *to* satisfaction of the individual deductible by one child. 3 *is* the maximum number allowed by the HealthMAPS program.
20. Lifetime Maximum (omit 000's)	$1,000	The benchmark plan's lifetime maximum is $1,000,000

Description	Input	Explanation
Mental Health and Substance Abuse:		
21. Outpatient - Coinsurance	80% or 50%	The benchmark plan pays 75% of outpatient mental health and substance abuse charges, after satisfaction of the plan deductible, if the insured is referred by a counselor from a mental health managed care company specified by the plan; and 50% otherwise. The HealthMAPS program only allows for one of two options: 80% and 50%.
22. Outpatient - Max. Covered Charge	$3,000 or $2,000	The coinsurance applies to a maximum of 30 visits per member with the referral described above, and to a maximum of 20 visits otherwise. HealthMAPS provides for entry of a dollar maximum, not a maximum number of days; the $3,000 and $2000 amounts are based on an estimate of a $100 per day average charge. (These provisions were effective January 1,1998, and replace the benefit description in Attachment 1. The current benefit provisions are described in Attachment 3).
23. Outpatient - Annual Maximum	$0.00	The benchmark plan's benefits are limited in terms of days of coverage, not by a dollar maximum
24. Include Outpatient Substance Abuse	Yes	The same benefits are provided for substance abuse as for mental health
25. Outpatient Adjustment Factor	0.9375 or 1.00	75%/80%=0.9375 is the factor to convert the 80% coinsurance option in HealthMAPS to the 75% coinsurance provided by the plan with the required counselor referral. Since the 50% coinsurance provided in the absence of this referral is a HealthMAPS option, the adjustment factor for this non-managed care counselor referral coverage is 1.00.
26. Inpatient - Max. Days	30	The durational limit defined by the benchmark plan for inpatient mental health and chemical dependency
27. Inpatient - Adjustment Factor	1.00 or 0.79	1.00 is the adjustment factor for in-network coverage; 0.79 is the factor for out-of-network coverage. HealthMAPS calculates the inpatient mental health and substance abuse cost as 3% of the base cost on line 1. The adjustment factors were calculated as the change in cost due to the different cost-sharing assumptions in the benchmark plan's provisions. See Exhibits VII and VIII.

Description	Input	Explanation
Extended Care Facility:		
28. ECF Daily Benefit	50% of R&B	The benchmark plan covers skilled nursing facility stays of up to 70 days. The Tillinghast Medical Manual's monthly cost calculation for "skilled nursing facilities" matches the HealthMAPS cost for "extended care facilities."
29. ECF Maximum Number of Days	70	The durational limit defined by the benchmark plan
Policy Specifications:	--	
30. Waiver of Coinsurance: OP Surgical	None	The benchmark plan provides for no such waiver
31. Supplemental Accident Maximum	$0	The benchmark plan provides no such benefit
32. Eliminate Prescription Drugs	Yes	The prescription drug coverage is calculated separately by the HealthMAPS Prescription Drug Card Costs program, as shown in Exhibits V and VI. The benefits vary depending on whether the prescription drugs are purchased by mail through a prearranged agreement with a specified pharmacy or are purchased directly from the pharmacy.
Copayments:		
33. Primary Office Visit Copay	$15	The benchmark plans copay requirement for allowable office visit charges
34. Specialist office Visit Copay	$15	The benchmark plans copay requirement for allowable office visit charges
35. Max. Number of Copays per Year	100	The benchmark plan provides no limit. An entry of 100 results in a "no limit" adjustment
36. Emergency Room Copay	$0	The benchmark plan provides for no such copay.
37. outpatient Surgical Center Copay	$0	The benchmark plan provides for no such copay.
Misc. In-Network Adjustment:		
38. None	60.00	Though the benchmark plan provides coverages not specifically accounted for in the HealthMAPS program, they are not adjusted for here because the CHIP coverage does not include them; therefore they are not needed for comparison purposes.

Description	Input	Explanation
Well Care Benefit:		
39. Nursery Benefits-Maternity on Kids	$656 or 6600	In-network and out-of-network values, reflecting the average in-hospital newborn costs for medical areas B and A respectively (obtained by multiplying the 1998 Medical Manual's assumption of an Area E average cost of $800 by 0.82 and 0.75).
Adjustment Factor	1.00	The HealthMAPS cost reflects the effects of the deductible and coinsurance inherent in the plan. Since the benchmark plan waives the deductible and coinsurance for newborn coverage, this cost will be derived from another source. The adjustment is irrelevant
41. Well Care Benefits Adult	No	Irrelevant; only the children costs are relevant
42. Adjustment Factor	No entry	Irrelevant; only the children factors are relevant.
43. Well Care Benefits Children - Physical Exam Only	No ancillary limit	None is provided in the benchmark plan
44. Total Expense Limit	$146	The plan pays up to $250 of well care benefit in the first year, and up to $125 in each of the following 5 years.. $250/6 + $125 x 5/6 = $146.
45. Benefits Terminate at Age	6	The benchmark plan provides well child preventive care through age 5.
46. Manual Cost (before adjustment)	No entry	Sum of the adjusted base cost from line 13 and the costs and cost adjustments produced by the input entries following line 13.

Description	Input	Explanation
Factor Adjustments:		
47. Experience Factor	0.526	The factor of 0.526 is a conversion of children rates to child rates (1/1.9). Tillinghast's children claim costs assume 1.9 children per family. An experience adjustment is not applicable, since the benchmark plan's value will be compared to a startup plan.
48. Underwriting Factor	1.03	This input reflects an increase in overall value because of benefits covered by the benchmark plan that are not included in Tillinghast's assumptions. This is actually an adjustment factor, not an underwriting factor.
49. Trend Factor	September 1998	HealthMAPS calculated 1.014 as the trend from July 1,1998, which is the start date of the 12-month period over which the HealthMAPS claim costs are effective, to September 1, 1998, when the CHIP program is estimated to take effect.
50. Age Gender Factor	Age 19	This entry results in a HealthMAPS adjustment to convert to Tillinghast's general assumption of coverage of students to age 23 and other children to age 19 to the CHIP provision of coverage to age 19 for all children.
51. Child "Coverage From"	From birth	The benchmark plan's provision
52. Pre-Admission Certification Factor	Yes	The benchmark plan's provision
53. SIC Factor	No	The benchmark plan has no SIC variations in premium
54. Final Total Manual Costs	No entry	Product of the manual cost before adjustments from line 46 and the adjustment factors from lines 47 through 53.

The prescription drug coverage is covered through a drug card program in the benchmark plan, and offers two different copay basts. Attachment 4, which is a copy of the description of the prescription drug benefit effective January 1, 1998 is attached. As described in Attachment 4, if the prescription drugs are purchased directly from the pharmacy, the copays consist of a $50 deductible, 70% coinsurance for brand name drugs, and 90% coinsurance for generic equivalents. The HealthMAPS calculation of the cost of this coverage is shown in Exhibit V. The plan also offers an option of mail order through a specified pharmacy. The copays are $30 per order for brand name drugs and $10 per order for generic drugs, 100% coverage after the copay. The HealthMAPS cost calculation for this coverage is shown in Exhibit VI. HealthMAPS calculates the base cost directly from the input information; the only adjustment is for trend. All entries in the input column were manually input except for the retail cost, which is entered by HealthMAPS as the Tillinghast default value.

Exhibits VII and VIII, referred to in the line 27 explanation column, demonstrates the calculation of the IP Adjustment Factor to apply to the cost automatically calculated by the HealthMAPS program. First each

exhibit shows the calculation of mental health and chemical dependency expected annual costs, and the resulting expected amount covered by the benchmark plan, using a methodology demonstrated in the "State Mandated Benefits" of the Tillinghast-Towers Pemn 1998 Medical Manual. All of the assumptions come from the Tillinghast demonstration, but rhc average daily cost for both mental and for substance abuse is 82% of the Tillinghast assumption to reflect an Area 8 cost for in-network service, and 75% of the Tillinghast assumption to reflect an Area A cost for out-of-network service. 80% of the expected annual cost is also shown to reflect the Tillinghast HealthMAPS program's calculation of the inpatient mental health and substance abuse cost for 30-day coverage as 3% of the base cost of a $750 deductible, 80% coinsurance plan with no stopioss beyond the lifetime *maximum.* The ratio of the benchmark plan result and the Tillinghast-based result is shown as the lightly-outlined percentage for both mental health and substance abuse coverage in each exhibit.

The calculation of HealthMAPS line 27 IP-Adjustment Factor is shown in the bottom half in each exhibit. In each case, the HealthMAPS claim cost is split into mental health and substance abuse costs. The Medical Manual assumes that the inpatient substance abuse cost is 30% of the inpatient mental health *cost.* Therefore the mental health portion of the HealthMAPS cost is estimated to be 1/1.3 times the total cost, and the substance abuse cost is estimated as 0.3/1.3 times the total *cost.* Each portion is then multiplied by *the* corresponding ratio calculated in the top half of the exhibit, and the two adjusted costs are added. In the *case* of the in-network cost, there is almost no difference, so a factor of 1.00 is the IP-Adjustment Factor input into the HealthMAPS program. In the out-of-network case, there is a significant difference, and the input factor is 0.79.

Exhibit IX shows the final calculation of benchmark plan actuarial value. Separate calculations are shown for in-network and out-of-network costs. The actuarial value is calculated in the third section, in which the assumed split between in-network and out-of-network utilization is 75%/25%. The children claim costs are equal to 1.9 x the child claim cost; the conversion to child cost is made for each benefit. The final column in the blended costs section discounts the child claim cost values by 4.8% for coverage of all children only through age 18 (the Tillinghast costs are based on the assumption that student coverage is through age 22).

The claim cost by benefit is derived as follows:

(1) The base cost on the first line is the sum of the Adjusted Base Cost (line 13) and the coinsurance adjustment shown on the Third Coinsurance Percentage line (line 18) of Exhibits I and III respectively.

(2) The percentages shown in connection with many of the benefits are taken *directly* from the distribution of comprehensive plan benefits on page II-2 of the 1998 Medical Manual's section titled "Comprehensive Major Medical Claim Costs." Each corresponding claim cost, with one exception, is simply the percentage times the base cost. The one exception is the cost of office visits; the same calculation is used, *then* the adjustment cost from line 35 of HealthMAPS is added to the product. (The value in the HealthMAPS program is not the total value of the cost of office visits, but a load for replacing the deductible with a small copay).

(3) The inpatient mental health and chemical dependency claim cost is the HealthMAPS claim cost, shown on the bottom half of Exhibits VII and VIII as the starting value of the IP-Adjustment Factor calculation, less the deduction indicated on line 27 which results from the IP-Adjustment Factor entry, plus a 20% load to cover partial hospitalization as a covered benefit of inpatient services.

(4) The cost of the extended care facility benefit is the HealthMAPS claim cost from line 29.

(5) The outpatient mental health and chemical dependency claim cost is a weighted average of the cost of such service upon referral by a counselor from a mental health managed care company specified by

the plan and the cost without such a referral The weighting is 75% for the cost with the referral and 25% for the cost without the referral In addition, the costs were adjusted for Area B and Area A costs by multiplying the blended cost by 0 82 and 0 75 respectively (HealthMAPS made no such adjustment)

(6) The cost of newborn coverage is the HealthMAPS claim cost from line 40 of Exhibit XII (which is the HealthMAPS output page for the CHIP actuarial valuation, which will be discussed later). That value is used rather than the ones from the benchmark plan output pages because the HealthMAPS program applies the deductible and coinsurance to the cost; under the benchmark plan provisions, the deductible and coinsurance'provisionsare waived for newborn coverage. Since the CHIP plan has no general cost-sharing (as will be discussed later), the value shown in Exhibit XII actually reflect the appropriate value for the benchmark plan.

It should be noted that, even though the coverage is labeled "Nursery Benefits" in the HealthMAPS program, the 1998 Medical Manual defines the same benefit as "Newborn Children" and includes coverage for illness immediately from the birth of a child, which is consistent with the benchmark plan's provisions.

(7) The well child care claim cost is derived from the HealthMAPS cost on line 2. Since HealthMAPS does not adjust the cost of this benefit by medical area, the costs shown in Exhibit IX reflect the HealthMAPS cost multiplied by 0.82 and 0.75 respectively.

(8) The prescription drug card cost is the average of the prescription drug card costs calculated as illustrated in Exhibits V and VI. It is assumed that half the benefits will be used through the mail order program and half from purchases directly fiom the pharmacy. No area adjustment is made, since the plan pays up to the plan allowance for prescriptions for non-network pharmacies as well as for network pharmacies.

(9) The cost of vision services is derived from the cost of vision care in the State Mandated Benefits section of the 1998 Medical Manual. Since the cost of vision hardware is not included in the benchmark plan's benefit, but is included in the Tillinghast rate, the cost is reduced by 73%. In addition, the cost is adjusted for Areas B and A by multiplying the result by 0.82 and 0.75 respectively. That result is then divided by 4 to account for the fact that the 1998 Medical Manual's cost includes the cost of lenses and frames. The benchmark plan's vision coverage only covers routine eye exams, which is estimated to be only 25% of the Medical Manual Cost. Finally, this result is multiplied by 75% to account for a $10 copay required by the benchmark plan (this copay is estimated to be 25% of the cost).

(10) As stated, hearing services are not covered under the benchmark plan.

The starting point of the calculation of the actuarial value of the Montana Children's Health Insurance Program plan is the Tillinghast HealthMAPS 1998 PMPM program. All the areas in the PMPM Lotus spreadsheet are protected Gom direct changes by a confidential password. The factors within the outlines are unprotected so that adjustment factors can be entered so that the resulting utilization rates and costs per unit of service are appropriate for the particular population to be covered under the plan.

Exhibit X shows the 1998 PMPM spreadsheet which calculates the cost of the majority of benefits covered by the CHIP plan. The calculation of the costs of the remaining benefits are shown in exhibits following this one, which will be discussed one by one. Below is a description of the types of adjustments in the outlined columns of Exhibit X which modify the Tillinghast assumptions to calculate the per member per month costs for the CHIP plan.

Column (B): The utilization adjustment factors in column (B) of Exhibit X adjust the utilization and cost per service from blended employee/spouse/children rates to appropriate child rates. Section III of the 1998 Medical Manual, titled "Per Member Per Month (PMPM) Costs," states that the PMPM claim cost level is "consistent with the utilization and cost per service inherent in this manual," and further states that "the benefits are the same as those whose utilization and costs are detailed on the more traditional basis in Section V." Thus basing the utilization adjustment factor on the ratio of the child claim cost to the blended employee/spouse/children claim cost for Medical Area B from Section V ("Distribution of Expenses and Continuance Tables") is deemed to be actuarially consistent with the HealthMAPS assumptions used to calculate the actuarial value of the benchmark plan.

The assumption in the 1998 PMPM spreadsheet is that the underlying population has the following characteristics: 48% of the members are employees, 22% are spouses, and 30% are children. Also, the costs are based on Medical Area E. Exhibit XI shows the Medical Area B employee, spouse and child annual claim costs fiom Section V. The blended claim costs in the fourth claim cost column uses the same 48%/22%/30% distribution assumed in the assumed in the *1998* PMPM model. Finally, the last column shows the ratio, as a percent, of each benefit's child cost to its blended cost. The utilization adjustment factors in Exhibit X are the percents shown in Exhibit XI. The factors were entered in Column (B) to four decimal places, though Exhibit X only shows the decimal rounded to two places. (The program will not allow a format adjustment to show the four-place decimal; however, the calculation uses the exact decimal entered).

The entries of "Manuai" in *this* column and in Columns (E) and (I) indicate that the benefit is included in the *CHIP* plan, but the PMPM has been calculated separately because of characteristics of the benefit that do not necessarily reflect the value of the benefit in the PMPM spreadsheet. Entries of N/A in these columns indicate that the benefit is not included in the *CHIP* plan.

Column (E) The discount adjustment factor in Column (E) is actually a combination of two adjustments: (a) a factor of 0.82 to convert the Area E costs per unit of service to Area B equivalents, and (b) a factor of *0.952* to convert the Tillinghast assumption of student coverage through age 22, which is inherent in the costs, to coverage of all children only through age 18. The factor of 0.78 shown in the column is actually *0.82* x *0.952* = 0.78064.

Column (G) The copay per unit of service is $0 *in* all cases except emergency room service. This copay per use is $3.00 for a true emergency and $6.00 for non-emergency use of the emergency room. The assumption is that half the utilization will be for emergency use and half for non-emergency use.

Column (J) The adjustment factor for the benefits for which utilization and claim cost assumptions were provided is simply 1.00, since all the necessary adjustments have already been made. For five different benefits the only assumption provided is the Area E cost per member per year. The final adjustment factor for each of these benefits is simply the product of the three adjustment factors (the child-to-blended expense ratio applicable to the benefit, the Area B conversion factor, and the age 18 limitation factor) indicated in the Column (B) and Column (E) descriptions.

Exhibit XII is the output page for the HealthMAPS program that was run to obtain some costs not included in the PMPM spreadsheet results. The explanation of the input would correspond to *the* explanation in the "Benchmark Plan HealthMAPS Guide" (adjusted for the characteristics of the CHIP plan). All entries in the

input column reflect the characteristics of the CHIP plan except those for the mental abuse and substance abuse section (lines 21 through 27) The CHIP plan's mental health and chemical dependency benefits correspond to Montana's mandated minimum coverage, which makes the features different enough from the options given by the HealthMAPS program that the input and the results in that section should be disregarded.

Only two CHIP plan monthly costs are taken from the HealthMAPS program. For this reason, the assumptions underlying the HealthMAPS calculation of only these two benefits will be discussed.

(1) The cost of newborn children coverage is derived from line 40 of Exhibit XII. As was explained previously, even though the HealthMAPS program calls the coverage "nursery benefits", the cost reflects that of full coverage of newborn children for the first 31 days after birth. The input value of $656 in line 39 is used by HealthMAPS to calculate the cost. $656, calculated as 82% of the Area E cost of newborn coverage used in the calculation of the newborn children cost in the State Mandated Benefits section of 1998 Medical Manual, is the estimated Area B newborn children cost.

(2) The well care benefit for children covers children of all ages under the CHIP plan, and covers both physical and gynecological exams. There is no specific expense limit; the input value of $500 on line 44 is interpreted by HealthMAPS as "no limit."

Exhibit XIII is the output of the HealthMAPS prescription drug card costs program. The CHIP plan covers 100% of the cost of prescription drugs, and also provides 100% coverage of birth control. HealthMAPS calculates the base cost directly from the input information; the only adjustment is for trend. All entries in the input column were manually input except for the retail cost, which is entered by HealthMAPS as the Tillinghast default value.

Exhibit XIV shows the calculation of inpatient and outpatient mental health costs and of inpatient and outpatient chemical dependency costs. The calculation of the inpatient mental health and chemical dependency costs uses the same methodology as the one used in calculating expected annual amount covered by the plan for the benchmark plan. The calculation of the monthly cost per child is then accomplished by multiplying this expected annual amount by the frequency assumption used in the 1998 Medical Manual's demonstration. Thid result is increased by 20% to cover partial hospitalization, as recommended in the Medical Manual's explanation.

The results of the calculation of the outpatient mental health and chemical dependency child costs are also shown on Exhibit XIV. The base costs of both coverages as defined by the CHIP plan (which provides the benefits on the same basis as the minimum required by Montana's insurance code) are provided in the 1998 State Mandated Benefits Manual: $4.15 for outpatient mental health and $0.78 for outpatient chemical dependency. Since these costs assume 80% coinsurance, the final cost was calculated as the base cost / 0.8, to reflect the conversion fiom 80% coinsurance to 100% coinsurance.

Exhibit XV shows the final calculation of the actuarial value of the CHIP plan. The benefits whose costs were not included in the 1998 PMPM spreadsheet are listed; the source of the base cost of each, with the exception of three separate benefits - immunizations, vision, and audiology - has already been explained. The source of the base cost of each of these is the State Mandated Benefits section of the 1998 Medical Manual. Following is a brief explanation of the derivation of each of the base cost for each of the three.

(1) The immunizations monthly cost from the manual is $3.50 for children. which is converted to a p a child basis by dividing by 1.9 to obtain $1.84.

(2) The vision cost from the manual is $3.33 per child, which is assumed to cover routine eye exam, refractions, lenses and frames. Since the CHIP plan does not cover optical hardware, the cost is divided by 4 to estimate the monthly cost of routine eye exams.

(3) The audiology-related coverage in the manual is labeled "treatment for loss or impairment of speech or hearing," and is described as "coverage of some extended benefits for an impairment which is chronic and not acute and might involve practitioners not generally covered or hearing aids or speech therapists to correct impediments not due to injury or sickness." The manual's monthly cost for children is 3.30, which is converted to a $.16 per child rate after dividing by 1.9. This rate is divided by 4 to remove the cost of coverage speech-related benefits and hearing aid (neither of which are covered by the CHIP plan).

The costs of these three benefits are the Area E cost. The Area B conversion factor column in Exhibit XV contain the factor of *0.82* for these three, and 1.00 for all others (since they were already converted in their calculations shown in previously-described exhibits). The conversion factor for coverage of all children through age 18 *(to* age *19)* is applied to all the base costs. The adjusted cost is the product of the base cost, the area conversion factor, and the age conversion factor.

The sum of these individual benefits and the grand total of the other plan benefits from the *1998* PMPM spreadsheet is shown as the overall grand total actuarial value of the CHIP plan.

Exhibit XVI lists the benefit categories used in the *1998* Medical Manual's traditional plan distribution of expenses as well as the additional categories priced separately. The actuarial values by benefit category for the benchmark plan and the *CHIP* plan are listed side by side. The values for the benchmark plan are taken directly from the right-hand column of Exhibit IX - the Benchmark Plan Actuarial Value Illustration. The value4 for the CHIP plan are *taken* from Exhibit X - the Fer Member Per Month Cost Distribution Model, and from Exhibit XV - the Calculation of the Actuarial Value for the Montana Children's Health Insurance Program. Following is an explanation of the division of the *CHIP* plan's costs into the traditional plan categories used to illustrate the benchmark plan's distribution.

Inpatient Hospital: The total cost from the Inpatient Hospital category on Exhibit X, less the Surgical cost

Inpatient Professional: The sum of the following *costs* from the physician section of Exhibit X: Surgical Inpatient, Normal Delivery, C-Section, Maternity Other, Anesthesia, and Professional Inpatient

Inpatient Mental Health and Chemical Dependency: The sum of the *costs* of these two coverages from Exhibit XV

Inpatient Surgical: The Surgical cost in the inpatient Hospital category of Exhibit X

Extended Care Facility: Not covered by the CHIP plan

Outpatient Hospital: The total cost from the Outpatient Hospital category on Exhibit X, less the Surgical cost

Outpatient Professional: The sum of the following costs from the physician section of Exhibit X: Surgical Outpatient, Surgical Office, and Professional Outpatient

Outpatient Mental Health and Chemical Dependency: The sum of the costs of these two coverages from Exhibit XV

Outpatient Surgical: The Surgical *Cost* in the Outpatient Hospital category of Exhibit X

Diagnostic X-Ray and Lab: The sum of the X-Ray and Lab costs in the Physician category of Exhibit X

Office Visits: The Office Visit cost in the Physician category of Exhibit X

Newborn Coverage: The Newborn Children cost from Exhibit XV

Well Child Care: The sum of the Well Child Care cost and the Immunizations cost in Exhibit XV

Prescription Drugs: The Prescription Drugs cost from Exhibit XV

Vision Services: The Vision cost from Exhibit XV

Hearing Services: The Audiology cost from Exhibit XV

The final exhibit, Exhibit XVII, shows the values of the services defined in Title XXI of the Social Security Act for the benchmark plan and the CHIP plan, and shows the ratio of the CHIP to the benchmark plan. The ratio column clearly shows that each of the CHIP categories has a higher value than the value of the corresponding category for the benchmark plan. This is largely due to the full dollar coverage of benefits under the CHIP plan (except for a small emergency room copay) versus the $750 deductible, 75% coinsurance on the next $5,000 before 100% coverage becomes effective under the benchmark plan.

The actuarial values of the basic services and the additional services are taken from the costs listed in Exhibit XVI. Following is an explanation the costs included in each service category's value.

Basic Services	Costs Used to Calculate the Services' Actuarial Value
Inpatient and Outpatient Hospital Services	The sum of the Inpatient Hospital and Outpatient Hospital costs
Physicians' Surgical and Medical Services	The sum of the Inpatient Professional, Inpatient Surgical, Outpatient Professional, Outpatient Surgical, and Office Visits costs
Laboratory and X-Ray Services	The Diagnostic X-Ray and Lab cost
Well-Baby and Well-Child Care	The sum of the Newborn Coverage and Well Child Care costs
Additional Services	**Costs Used to Calculate the Services' Actuarial Value**
Coverage of prescription Drugs	The Prescription Drugs cost
Mental Health Services	The sum of the Inpatient Mental Health and Chemical Dependency and the Outpatient Mental Health and Chemical Dependency costs
Vision Services	The Vision Services cost
Hearing Services	The Hearing Services cost

The total value of the benchmark plan in Exhibit XVII is 32.50 less than the benchmark plan's total cost in Exhibit XVI because of the exclusion of the costs of extended care facility coverage and of the "other miscellaneous" category in the actuarial value calculation.

This completes the explanation of the calculation and comparison of the actuarial values of the Montana Children's Health Insurance Program's proposed plan and of the State Basic Plan chosen as the benchmark benefit coverage required by Tide XXI. I certify that, to the best of my knowledge and judgment and relying on the accuracy and validity of the assumptions in the Tillinghast-Towers Perrin 1998 Medical Manual, in

the accompanying software, and in 1998 State Mandated Benefits Manual, the aggregate actuarial value of the CHIP plan is greater than the actuarial value of the benchmark benefit package; that the actuarial value of each of the CHIP plan's basic services and of each of its additional services, as defined in Title XXI, is greater than the actuarial value of the corresponding service under the benchmark plan; and that the Montana Children's Health Insurance Program health plan meets the requirements of Title XXI with respect to its actuarial value in relation to the *actuarial* value of the benchmark benefit package.

4/8/98

Margaret A. Miksch, ASA, MAAA
Lift and Health Actuary
Montana Insurance Department

Date

EMPLOYEE [illegible]EDICAL PLANS

•Benefits in Et[illegible] September 1, 1994•

General Benefit Description	TRADITIONAL & MEDICARE COORDINATED		BASIC		HMO	
	Maximum Plan member responsibility for allowable* expenses per:					
	Individual	Family	Individual	Family	Individual	Family
ANNUAL DEDUCTIBLE: First allowable* medical expenses each benefit year paid entirely by Plan member(s)	$200	$600	$750	$1,500	~~$0~~ $100	~~$0~~ $300
			Deductible does not apply to physician office visits		Annual referral deductible on outpatient non-PCP** professional services to which member is referred by the PCP	
COPAY: Portion of allowable* medical expenses paid by Plan member(s) after the deductible	25% of next $3,000	25% of next $6,000	25% of next $5,000	25% of next $10,000	No general copay $300 copay per member per hospital visit $50 copay per emergency room use $10 copay per office visit	
	See Specific Benefits for Exceptions		$15 per office visit See Specific Benefits for Exceptions			
OUT-OF-POCKET MAXIMUM: Maximum allowable* expenses Plan member(s) pay(s) each benefit year before Plan pays 100% of remaining allowable* expenses.	*$950*	$2,100	$2,000	$4,000	~~$750~~ +$100	~~$1,500~~ +$300
	See Specific Benefits for Exceptions		See Specific Benefits for Exceptions		Annual referral deductible *on* referred outpatient professional services by non-PCP See Specific Benefits for Exceptions	

SPECIFIC BENEFIT DESCRIPTION	TRADITIONAL, MEDICARE COORDINATED & BASIC PLANS	HMO PLAN
Office/Clinic Visit	Outpatient services **by a physician** or surgeon for **treatment** of an injury or illness. Subject to annual deductible **and general copay.**	Outpatient services rendered by a physician or surgeon for treatment of an injury or **illness.** Member **pays $15 copay on** allowable office visit charges. **Allowable charges** for **any ancillary** services **are** subject to annual deductible and general copay.	Professional services performed by or approved/referred by PCP. PCP referred visits to another **physician** are subject to annual referral deductible. Visits without PCP referral are not covered. Member pays a $10 copay per PCP office visit and, after the referral deductible, a $10 copay on allowable charges per referred non-PCP office visit.
Hospital Inpatient Medical/Surgical	**Inpatient services during hospital days certified as medically necessary. Subject to annual deductible and general copay.**	**Inpatient services during hospital days certified as medically necessary. $300 copay per member per hospital admission.**
Hospital/Surgi-Center Outpatient Medical/Surgical	**Outpatient services of hospital/center and professional services of physicians, surgeons, and anesthesiologists or anesthetists for medically necessary surgery and medical care. Subject to annual deductible and general copay.**	**Outpatient services of hospital/center and professional services of physicians, surgeons and anesthesiologists or anesthetists when referred by PCP. No copay on facility charge; Plan pays 100% of allowable charges. $10 copay on professional charges per office visit. Non-PCP professional services are subject to annual referral deductible.**
Diagnostic Xray, Lab, Chemotherapy, and Radiation	**Subject to annual deductible and general copay.**	**No copay; Plan pays 100% of allowable charges for services ordered by PCP or other provider to whom member has been referred by PCP. Subject to annual referral deductible if provided by other than PCP.**
Emergency Room	Services for surgery, accident or medical emergency only. Subject to annual deductible and general **copay.**	**Services for authorized emergency use only. $50 copay per visit, unless member admitted for inpatient hospital care.**
Preventive Services	DEDUCTIBLE COPAY EXCEPTION Well child care, including immunizations, from moment of birth paid at 100% of allowable charges up to **first-year** maximum of $250 and subsequent year maximum of $125 per year through age **five.** Schedule of adult preventive tests - pap smears, mammograms, and proctoscopic exams. Not subject to annual **deductible.** General copay applies - **$15 Basic copay waived.**	**When performed by the PCP, physical exams (at PCP's discretion), gynecological exams, hearing exams and well child care, including immunizations. Subject to $10 copay per office visit.**
Ambulance Services	For medical emergency to nearest qualified hospital within 500 miles. Subject to annual deductible **and** general copy.	**For medical emergency to nearest appropriate facility. *No copay; Plan pays 100% of allowable charges.***
Durable Medical Equip/Supplies and	Preauthorization required for **replacement/repair.** Allowable charges paid for **foot orthotics** limited to **$100 per foot in any** 12-month period. Subject to annual	**Paid at 80% of allowable charges when ordered by PCP or other**

Attachment 1, page Appendix A-16

Transportation	Reasonable expenses for one-way travel to out-of-state facility for treatment not available in Montana.	Reasonable expenses for one-way travel to out-of-state facility for treatment not available in Montana.
Chemical Dependency	INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary. Limited to a maximum of $4,000 in a 24-month period, $8,000 per member per lifetime. Subject to annual deductible and general copay. OUTPATIENT - Professional services paid at 75% of allowable charges (after deductible) up to a maximum of $2,250 per member per benefit year when referred by an EAP counselor; paid at 50% of allowable charges (after deductible) up to a maximum of $1,500 when not referred by an EAP counselor. Member pays other 25%/50% which does not apply to out-of-pocket maximum.	INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary when authorized by the PCP. Limited to a maximum of $4,000 in a 24-month period, $8,000 per member per lifetime. After the $300 inpatient copay, Plan pays 100% of allowable charges up to the maximum benefit. OUTPATIENT - Professional services paid at 75% of allowable charges up to a maximum of $2,250 per member per benefit year when referred by PCP. Member pays 25% which does not apply to out-of-pocket maximum. No benefits when not referred. Referred non-PCP professional services are subject to annual referral deductible.
Mental Health Care	INPATIENT - Up to 30-days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary. After annual deductible, the Plan pays 80% of allowable charges of a Preferred Provider Network facility until member reaches annual out-of-pocket maximum, then 100%. Plan pays 60% of allowable charges of an out-of-network facility until member reaches annual out-of-pocket maximum, then 80%. OUTPATIENT - Professional services paid at 75% of allowable charges (after deductible) up to a maximum of $2,250 per member per benefit year when referred by an EAP counselor; paid at 50% of allowable charges (after deductible) up to a maximum of $1,500 when not referred by an EAP Counselor. Member pays other 25%/50% which does not apply to out-of-pocket maximum. Partial hospitalization days may be exchanged for inpatient days at a rate of one (1) inpatient day for two partial days up to a maximum of 15 inpatient days.	INPATIENT - Up to 30 days of combined mental/nervous, chemical dependency benefits per benefit year during hospital days certified as medically necessary when authorized by the PCP. After the $300 hospital copay, Plan pays 100% of allowable charges of a Preferred Provider Network facility and 60% of allowable charges of out-of-network facility until member reaches annual out-of-pocket maximum, then 80%. OUTPATIENT - Professional services paid at 75% of allowable charges up to a maximum of $2,250 per member per benefit year when referred by a PCP. Member pays 25% which does not apply to out-of-pocket maximum. No benefits when not referred. Referred non-PCP professional services are subject to the annual referral deductible. Partial hospitalization days may be exchanged for inpatient days at a rate of one (1) inpatient day for two partial days up to a maximum of 15 inpatient days.
Physical, Occupational & Speech Therapy	INPATIENT - Up to 60 days of rehabilitation services per benefit year during hospital days certified as medically necessary. Subject to annual deductible and general copay. OUTPATIENT - Limited to $2,000 per benefit year, for all outpatient rehabilitative services. Subject to annual deductible and general copay.	INPATIENT - Up to 60 days of rehabilitation services per benefit year during hospital days certified as medically necessary. Subject to $300 hospital copay. OUTPATIENT - Services to which member is referred by PCP. Benefits limited to $2,000 per benefit year for all outpatient rehabilitative services. Subject to $10 copay per office visit and annual referral deductible on referred non-PCP professional services.
Maternity	Obstetrical care including delivery, prenatal, postpartum. Subject to annual deductible and general copay.	Obstetrical care including delivery, prenatal, postpartum. $150 copay per delivery for physician services. $300 copay for hospital stay.
Newborn Care	DEDUCTIBLE/COPAY EXCEPTION Plan pays 100% of allowable charges for physician/lab services for newborn care during post-natal hospitalization. Not subject to annual deductible. General copay applies to other services.	Routine newborn care not subject to separate hospital copay unless infant admitted for non-routine treatment.
Hospice	Hospice care up to plan limits when ordered by patient's attending physician. Subject to annual deductible and general copay.	Hospice care up to plan limits when ordered by PCP. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on non-PCP professional services.
Skilled Nursing	Up to 70 days during a convalescent period during any one benefit year. Subject to annual deductible and general copay.	Up to 70 days during a convalescent period during any one benefit year when ordered by PCP. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on non-PCP professional services.
Chiropractic	Includes therapeutic, palliative and rehabilitative care. Up to a maximum 25 visits per benefit year and $30 per visit. Subject to annual deductible and general copay.	Includes therapeutic, palliative and rehabilitative care. Up to a maximum of 25 visits per benefit year and $30 per visit when referred by PCP. Subject to $10 office visit copay and annual referral deductible on referred non-PCP professional services.
Acupuncture	Limited to treatment of injury or illness. Up to a maximum of 25 visits per benefit year and $30 per visit. Subject to annual deductible and general copay.	No coverage.
Home Health Care	Up to 70 days of service during any one benefit year. Home health aide services in excess of four hours in any one day shall be considered an additional day. Subject to annual deductible and general copay.	Up to 70 days during one benefit year, when ordered by PCP. Home health aide services in excess of four hours in any one day shall be considered as an additional day. No copay; Plan pays 100% of allowable charges. Subject to annual referral deductible on referred non-PCP professional services.
Organ Transplant	Lifetime maximum allowances for the following human-to-human organ transplant: Liver; Heart; Lung; Heart/Lung; Bone Marrow; Pancreas. Contact the Employee Benefits Bureau for specific allowance per transplant. Allowable charges for Cornea and kidney transplants are also covered. All transplants must be certified as medically necessary. Subject to annual deductible and general copay.	Lifetime maximum allowances for the following human-to-human organ transplant: Liver; Heart; Lung; Heart/Lung; Bone Marrow; Pancreas. Contact the Employee Benefits Bureau for specific allowance per transplant. Allowable charges for Cornea and kidney transplants are also covered. All transplants must be certified as medically necessary and ordered by PCP. Subject to $300 hospital copay and annual referral deductible on non-PCP professional services.
* ALLOWABLE CHARGES - Under all three Plans, only charges within Plan allowances are covered. Charges by physicians and other health care providers which exceed allowances are not paid by the Plans or credited toward deductible or out-of-pocket maximum. Plan members are responsible for paying unallowed charges		**PCP (Personal Care Physician) - The HMO participating physician you select to

CHAPTER 3

MEDICAL PLAN BENEFITS

K. THE PORTION OF COVERED MEDICAL EXPENSES WHICH ARE PAID BY THE PLAN

K-1 Allowable Charges

Allowable *charges* are charges which are:

1. covered medical expenses (as defined in Sections L and M of this Chapter); and;
2. within Usual, Customary, and Reasonable limits (UCR) (see definition in Chapter 9).

Allowable charges appear in the "approved for payment" column of the explanation of benefits (EOB) form. *Only* these charges will be:

1. credited *toward* your deductible;
2. credited toward any co-payment you must make; and/or;
3. paid by the Plan as described in the following provisions (K-2 and K-3).

Disallowed charges are not paid by the Plan or credited toward your deductible or co-payment. (See the *EOB* illustration in Appendix A.)

When covered medical expenses (as defined in Sections L and M), are not allowed because they exceed Usual, Customary, and Reasonable limitations (UCR), it is generally due to one of the following reasons:

1. the provider's charges *are* out of line - higher than *90 percent* of the *charges fur the* service by all similar providers in the state in which the *service* was received; or
2. *the* claims administrator (Blue Cross and Blue Shield) has not received *correct* information on *the service* provided (the procedure code on the claim could be incorrect or there could be complications not reflected on the claim).

Most Montana Physicians have agreed *to* accept Blue Cross and Blue Shield or State Plan UCR allowances and not require you to pay charges which exceed allowances. You will receive lists of these member physicians periodically and you may ask your physician directly if he or she is a member physician. The allowance for non-member Montana Physicians is 10 percent below the allowance for member physicians.

For non-emergency procedures you plan to receive from a non-member physician, you *can* determine in advance what charges will be allowed by obtaining a predetermination (see provision *G-3)*.

benefits as specified in the State Employee Group Benefit Plan or the family member is nor covered under. State Health Insurance, you are solely responsible for the costs associated with the outside assistance.

When referral to additional counseling is made and the referred counseling is for a State Health Insurance plan member and for a covered service as specified in the State Employee Group Benefit Plan, payment for the additional counseling is made as follows:

a) Outpatient Services under the Traditional and Basic Plans:

After the annual deductible is met, payment will be 75% of allowable charges up to a maximum of 30 visits per member per benefit year with a referral from an EAP counselor. You will be responsible for the 25% copy, any amounts above allowable charges (if you use a nun-member provider), and for any amounts above the 30 visit benefic year maximum.

Without a referral from an EAP counselor, counseling services will continue to be paid at 50% of allowable charges (after deductible) up to a maximum of 20 visits per member per benefit year.

b) Outpatient Services under an HMO:

When your EAP counselor recommends additional counseling or treatment, the counselor will consult, with your written approval, with your HMO Personal Cart Physician regarding a referral. When referral to recommended care is made by your Personal Cure Physician, payment will be 75% of allowable charges up to a maximum of 30 visits per member per benefit year just as it is under the Traditional and Basic Plans with an EAP counselor's referral.

Under an HMO, all spccialry care requires a referral from your Persona! care Physician. If you do nor have your Personal Care Physician's rcfcrral, you will be solely responsible for all incurred costs.

c) Inpatient Services:

Payment for medically necessary *chemical dependency* and *mental health care* will be paid as defined in the State Employee Group Benefit Plan. When inpatient care is recommended, your EAP counselor, with your approval, will work with Managed Care Montana to certify medical necessity and, if you arc covered by an HMO, with your Personal Care Physician to obtain a referral,

PHONE NUMBERS BY LOCATION

Billings	**(406)** 254-6263
Bozeman	(406) **587-8238**
Butte	**(406)** 782-0471
Great Falls	(406) 727-4358
Helena	**(406) 443-1127**
Kalispell	(406) **752-6443**
Miles City	(406) 232-3040
Missouia	(406) 327-7000
All Other Locations	(800) **999-1077**

For 24-hour, seven days per week crisis

Attachment 4

Agenda #: A-20

, :red State Employees, Retirees and Dependents

The State of Montana has contracted with Express Scripts and Buttrey Food and Drug to provide you the convenience and cost savings of a Prescription Drug card and Mail Order Plan. This plan allows you to meet your prescription needs by:

1. obtaining up to A 30-day supply or 100 pills, whichever is greater, of all covered prescriptions from a local pharmacy in the Express Scripts Network.
2. obtaining up to A 90-day supply of covered tong term prescriptions through a mail order service provided by Buttrey Food and Drug.

Advantages of Using Your New Card and Mail Order Options

- You pay only your portion of the costs when you obtain your prescriptions
- No paperwork
- NO claim forms to file
- Lower prescription drug costs for you and your health plan
- The added peace of mind of sophisticated computer edits to identify possible problems . . . dangerous drug interactions, dangerous dosage amounts.etc.
- the added convenience and cost savings of mail-order for long term prescriptions.

Other Plan Features

Licensed pharmacists are available around the clock to consult with members about their medicines. Express Scripts' Help Desk staff answers network pharmacist's questions to ensure you get timely service at their pharmacy.

Your new Prescription Drug Plan has been designed to offer plan members the combination of:

- Quality
- Cost Savings
- Convenience
- Service

Please familiarize yourself with the specific terms and conditions of your prescription drug coverage. You will receive the maximum coverage of Rx costs that you are entitled to under the terms of your plan when you fill your prescriptions at participating pharmacies and the mail order service.

How Your Plan Works

When you mail order:

I. Consider mail order for maintenance medications. These are medications taken on a regular basis over months or years to treat long-lasting or chronic conditions. Unlike medications needed unexpectedly and immediately, they can be put on a mail order schedule.

2. Have your doctor write a prescription for up to a 90-day supply, where appropriate, plus refills. Since maintenance prescriptions typically don't change, it is usually more convenient and less costly to get a 90-day supply at a time. You save money both on low mail order rates and from paying one co-payment rather than several.

3. Complete the Patient Profile/Order Form and enclose your original prescription along with:
   - a co-payment of $10 for a generic prescription
   - a co-payment of $30 for a brand name
   - mail service prescriptions are not subject to deductible

   If you are unsure of whether your prescription is brand name or generic, you may call Buttrey's toll free number below or send $30. If your prescription is generic, you will receive a $20 credit which you may use for your next prescription. You may send a check, money order or you may charge the amount to your VISA, Discover or MasterCard.

4. Refill orders by simply calling the toll-free number. The prescription label will indicate the number of times you may have a prescription refilled. If you charge your co-payment of $10 for Generic drugs or $30 for Brand name drugs to your credit card you needn't mail anything for a refill.

5. A pharmacists will check for any potential problems with drugs you are currently using, potential allergic reactions and other clinical and administrative problems with the aid of the Express Scripts computer network.

6. Upon verification that both the patient and drug requested are covered, the pharmacist will send the prescription. Allow 7 to 10 working days for delivery. Prescriptions are delivered directly to your home, postage-paid along with ordering instructions and forms for refills and/or new prescriptions.

For Mail Order Customer Service and Refill Orders Call Toll-Free

When you go to a Network Pharmacy:

1. Present the Express Scripts PERx ID Card to any participating pharmacy along with your prescription.
2. The pharmacist keys in your member ID number and prescription information to the Express Scripts on-line system.
3. The pharmacist will check for any potential problems with drugs you are currently using, potential allergic reactions and other clinical and administrative problems with the aid of the Express Scripts computer network.
4. Upon verification that both the patient and the drug requested are covered by the plan, the pharmacist will instruct you as to your deductible and co-payment obligation. You pay the pharmacist your obligation and receive your prescription.
5. Your obligation:

   Co-pay: 10% for generic drugs
   30% for brand name drugs

   Deductible: The first $50 of charges per member *(a maximum of $150 per family)* in the benefit year.

For Network Customer Service or General Information on Medications Call Toll-Free-1-800-206-4005

When you go to a Pharmacy Out-Of-Network (cash & carry):

If for some reason you are unable to use A participating network pharmacy and need to purchase a prescription outside the network, you may do so and be
Simply pay for your prescription, obtain a receipt from the pharmacy showing the name of the drug, dosage, strength and price and date of service. Then obtain a claim form from the Employee Benefits Bureau and send it to the address shown on the form. Your claim will be processed and you will be reimbursed according to your Plan Benefit subject to deductible and co-payment Reimbursement will not exceed the amount that would have been paid if the prescription were purchased at an Express Scripts Network Pharmacy.

After the member has paid $300 out-of-pocket

Tillinghast-Towers Perrin Medical Manual Costs–1998

In-Network Monthly Costs

Company Name: Montana Insurance Dept
Plan Name: State Basic Plan
Sub Name: In-Network, EAP Counselor

Effective Date: September 1996
Rates Guaranteed: 12 months
Medical Area: B
SIC: No Adjustment

Pre-admission Certification: Yes
Deductible Plan Type: All Expenses
PPO Participation: 100%

		Input	Employee	Spouse	Children	Comp. Dep	Retiree
1	Base Cost:		$119.23	$140.14	$81.23	$160.33	$262.95
	Deductible:						
2.	Calendar Year Deductible (combined)	$750					
3.	Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4.	Eliminate Carry-Forward	Yes	(4.80)	(4.80)	(2.93)	(8.25)	(8.56)
5.	Deductibles Per Family	4.00			(6.50)	(4.87)	
6.	Hospital Deductible Per Admission	$0	0.00	0.00	0.00	0.00	0.00
7.	Waive Deductible for Surgery						
	Policy Specifications:						
8.	In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9.	In-full Hospital Amount	$0	0.00	0.00	0.00	0.00	0.00
10.	ICU Maximum	Unlimited	1.31	1.31	0.87	1.74	4.80
	Covered Level:						
11.	Room and Board	$545	0.00	0.00	0.00	0.00	0.00
12.	Surgical	$106	0.00	0.00	0.00	0.00	0.00
13.	Adjusted Base Cost:		$115.74	$136.65	$72.67	$170.95	$258.17
13a.	PPO Discount Value (at 90%)		0.00	0.00	0.00	0.00	0.00
	Coinsurance - General:						
14.	First Coinsurance Percentage	75%					
15.	on first $x incurred after ded	$5,000					
16.	Second Coinsurance Percentage	100%					
17.	on next $Y incurred	$0					
18.	Third Coinsurance Percentage	0%	11.35	12.18	3.90	13.61	34.23
19.	Stop-loss Max Per Family	3.00			0.00	0.00	
20.	Lifetime Maximum (omit 000's)	$1,000	0.00	0.00	0.00	0.00	am
	Mental Health and Substance Abuse:						
21.	OP - Coinsurance	80%					
22.	OP - Max Covered Charge	$3,000					
23.	OP - Annual Maximum	$0					
24.	Include OP Substance Abuse	Yes					
25.	OP - Adjustment factor	0.94	12.36	12.36	11.65	18.82	25.56
26.	IP - Max Days	30					
27.	IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	am
	Extended Care Facility:						
28.	ECF Daily Benefit	$273					
29.	ECF Maximum Number of Days	70	1.64	1.91	1.36	2.73	9.81
	Policy Specifications:						
30.	Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	am
31.	Supplemental Accident Maximum	$0	0.00	0.00	0.00	0.00	am
32.	Eliminate Rx Drugs	Yes	(9.91)	(11.65)	(8.75)	(14.99)	(21.86)
	Co-payments:						
33.	Primary Office Visit Co-pay	$15					
34.	Specialist Office Visit Co-pay	$15					
35.	Max Number of Co-pays Per Year	100	1.50	1.89	5.67	5.22	(0.66)
36.	Emergency Room Co-pay	$0	0.00	0.00	0.00	0.00	0.00
37.	Outpatient Surgical Center Co-pay	$0	0.00	0.00	0.00	0.00	0.00
	Misc. In-Network Adj.:						
38.	Adjustment for Additional Benefits in the State Plan		0.00	0.00	0.00	0.00	0.00
	Well Care Benefit:						
39.	Nursery Benefits - Maternity On Children	$656					
40.	Adjustment Factor	1.00	0.69	2.64	1.15	2.50	
41.	Well Care Benefits, Adult - No	NA					
42.	Total Expense Limit	NA	0.00	0.00		0.00	0.00
43.	Well Care Benefits, Children - Phy Exam Only	No Anc Lmt					
44.	Total Expense Limit	$146					
45.	Benefits Terminate Upon Attainment of Age	6			3.20		
46.	Manual Cost (before factor adjustments)		$133.36	$155.76	$92.84	$196.84	$306.23
	Factor Adjustments:						
47.	Experience Factor	0.526					
48.	Underwriting Factor	1.030					
49.	Trend Factor	1.0140					
50.	Age Gender Factor	Yes	1.000	1.000	0.952	0.964	1.000
51	Child "Coverage From" (additive)	From Birth		0.000		0.000	
52.	Pre-Admission Certification Factor - Yes	1.000					
53.	SIC Factor - No	1.000					
54	Final Total Manual Costs		$73.32	$86.62	$48.56	$127.66	$168.33

Towers Perrin Medical Manual Costs--1998
In-Network Monthly Costs

Company Name: Montana Insurance Dept
Plan Name: State Basic Plan
Sub Name: In-Network no EAP Counsel
Effective Date: September 1998
Rates Guaranteed: 12 months
Medical Area: 8
SIC: No Adjustment
Pre-admission Certification: Yes
Deductible Plan Type: All Expenses
PPO Participation: 100%

		Input	Employee	Spouse	Children	Comp. Dep	Retiree
1	Base Cost:		$119.23	$140.14	$81.23	$160.33	$262.95
	Deductible:						
2.	Calendar Year Deductible (combined)	$750					
3.	Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4.	Eliminate Carry-Forward	Yes	(4.80)	(4.80)	(2.93)	(8.25)	(8.56)
5.	Deductibles Per Family	4.00			(8.50)	(4.87)	
6.	Hospital Deductible Per Admission	$0	0.00	0.00	0.00	0.00	0.00
7	Waive Deductible for Surgery						
	Policy Specifications:						
8.	In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9.	In-full Hospital Amount	$0	0.00	0.00	0.00	0.00	0.00
10.	ICU Maximum	Unlimited	1.31	1.31	0.87	1.74	4.80
	Covered Level:						
11.	Room and Board	$545	0.00	0.00	0.00	0.00	0.00
12.	Surgical	$108	0.00	0.00	0.00	0.00	0.00
13.	Adjusted Base Cost:		$115.74	$136.65	$72.67	$170.95	$259.17
13a.	PPO Discount Value (at 80%)		0.00	0.00	0.00	0.00	0.00
	Coinsurance - General:						
14.	First Coinsurance Percentage	75%					
15.	on first $x incurred after ded	$5,000					
16.	Second Coinsurance Percentage	100%					
17.	on next $Y incurred	$0					
18.	Third Coinsurance Percentage	0%	11.35	12.16	3.90	13.61	34.23
19.	Stop-loss Max Per Family	3.00			0.00	0.00	
20	Lifetime Maximum (omit 000's)	$1,000	0.00	0.00	0.00	0.00	0.00
	Mental Health and Substance Abuse:						
21	OP - Coinsurance	50%					
22	OP - Max Covered Charge	$2,000					
23.	OP - Annual Maximum	$0					
24.	Include OP Substance Abuse	Yes					
25	OP - Adjustment factor	1.00	7.85	7.85	6.45	11.34	18.44
26.	IP - Max Days	30					
27.	IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	0.00
	Extended Care Facility:						
28.	ECF Daily Benefit	$273					
29.	ECF Maximum Number of Days	70	1.64	1.91	1.36	2.73	9.81
	Policy Specifications:						
30.	Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31.	Supplemental Accident Maximum	$0	0.00	0.00	0.00	0.00	0.00
32.	Eliminate Rx Drugs	Yes	(9.91)	(11.85)	(8.75)	(14.99)	(21.86)
	Co-payments:						
33.	Primary Office Visit Co-pay	$15					
34.	Specialist Office Visit Co-pay	$15					
35.	Max Number of Co-pays Per Year	100	1.50	1.89	5.67	5.22	(0.68)
36.	Emergency Room Co-pay	$0	0.00	0.00	0.00	0.00	0.00
37.	Outpatient Surgical Center Co-pay	$0	0.00	0.00	0.00	0.00	0.00
	Misc. In-Network Adj.:						
38.	Adjustment for Additional Benefits in the State Basic Plan		0.00	0.00	0.00	0.00	0.00
	Well Care Benefit:						
39.	Nursery Benefits - Maternity On Children	$656					
40.	Adjustment Factor	1.00	0.89	2.64	1.15	2.50	
41.	Well Care Benefits, Adult - No	NA					
42.	Total Expense Limit	NA	0.00	0.00		0.00	0.00
43	Well Care Benefits, Children - Phy Exam Only	No Anc Lmt					
44	Total Expense Limit	$146					
45	Benefits Terminate Upon Attainment of Age	6			3.20		
46	Manual Cost: (before factor adjustments)		$126.87	$151.25	$87.65	$191.36	$297.11
	Factor Adjustments:						
47	Experience Factor	0.526					
48	Underwriting Factor	1.000					
49	Trend Factor	1.0140					
50	Age Gender Factor	Yes	1.000	1.000	0.952	0.964	1.000
51	Child "Coverage From" (additive)	From Birth		0.000		0.000	
52	Pre-Admission Certification Factor - Yes	1.000					
53	SIC Factor - No	1.000					
54	Final Total Manual Costs		$70.84	$83.14	$46.87	$103.31	$163.32

Tillinghast-Towers Perrin Medical Manual Costs—1998
Out-of-Network Monthly Costs

Company Name	Montana Insurance Dept	Effective Date:	September 1998	Pre-admission Certification:	Yes
Plan Name	State Basic Plan	Rates Guaranteed:	12 months	Deductible Plan Type:	All Expenses
Sub Name	Out-of-Network, EAP Counse	Medical Area:	A	PPO Participation:	0%
		SIC:	No Adjustment		

		Insrd	Employee	Spouse	Children	Comp. Dep	Retiree
1	Base Cost:		$107.77	$126.68	$72.34	$162.30	$239.85
	Deductible:						
2	Calendar Year Deductible (combined)	$750					
3	Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4	Eliminate Carry-Forward	Yes	(4.80)	(4.80)	(2.93)	(8.25)	(8.58)
5	Deductibles Per Family	4.00			(5.79)	(4.34)	
6	Hospital Deductible Per Admission	$0	0.00	0.00	0.00	0.00	0.00
7	Waive Deductible For Surgery						
8.							
9	In-full Hospital Amount	0.00	0.00	0.00	0.00	0.00	0.00
10	ICU Maximum	$0	0.00	0.00	0.00	0.00	0.00
	Covered Level:	Unlimited	1.21	1.21	0.80	1.61	4.43
12	Surgical	$503	0.00	0.00	0.00	0.00	0.00
		$97	0.00	0.00	0.00	0.00	0.00
13	Adjusted Base Cost:		$104.18	$123.09	$64.42	$153.32	$235.70
	Coinsurance - General:						
14	First Coinsurance Percentage	75%					
15	on first $x incurred after deductible	$5,000					
16	Second Coinsurance Percentage	100%					
17	on next $Y incurred	$0					
18	Third Coinsurance Percentage	0%	9.47	10.09	3.49	11.46	28.78
19	Stop-loss Maximum Per Family	3.00			0.00	0.00	
20	Lifetime Maximum (omit 000's)	$1,000	0.00	0.00	0.00	0.00	0.00
	Mental Health and Substance Abuse						
21	Coinsurance	80%					
22	OP - Max Covered Charge	$3,000					
23	OP - Annual Maximum	$0					
24	Include OP Substance Abuse	Yes					
25	OP - Adjustment Factor	0.94	1240	1240	11.88	18.87	25.83
26	IP - Max Days	30					
27	IP - Adjustment Factor	0.79	(1.09)	(1.28)	(0.46)	(1.40)	(2.42)
	Extended Care Facility						
28	Family Ben	$252					
29	ECF Maximum Number of Days	70	151	1.76	1.26	252	9.05
	Policy Specifications:						
30	Waiver Of Coinsurance For OP Surgical	None	am	0.00	0.00	0.00	0.00
31	Supplemental Accident Maximum	$0	0.00	0.00	0.00	0.00	0.00
32	Eliminate Rx Drugs	Yes	(9.23)	(10.85)	(6.20)	(13.90)	(20.55)
	Co-payments:						
33	Primary Office Visit Co-pay	$15					
34	Specialist Office Visit Co-pay	$15					
35	Max Number of Co-pays Per Year	100	119	1.34	4.90	449	(1.26)
36	Emergency Room Co-pay	$0	0.00	0.00	0.00	0.00	0.00
37	Outpatient Surgical Center Co-pay	$0	0.00	0.00	0.00	0.00	0.00
	Misc. Out-of-Network Adj.:						
38	Adjustment for Additional Benefits in the State Plan		am	0.00	000	0.00	0.00
	Well Care Benefit:						
39	Nursery Benefits - Maternity On Children	$600					
40	Adjustment Factor	1.00	0.60	234	1.00	222	
41	Well Care Benefits, Adult - No	NA					
42	Total Expense Limit		am	0.00		0.00	0.00
U	Well Care Benefits, Children - Phy Exam Only	No Anc Limit					
44	Total Expense Limit	$148					
45	Benefits Terminate Upon Attainment of Age	8			$83.29	$177.48	
46	Manual Cost: (before factor adjustments)		$119.02	$133.59			$274.92
	Factor Adjustments:						
47	Experience Factor	0.526					
48	Underwriting Factor	1.030					
49	Trend Factor	1.0140					
50	Age Gender Factor	Yes	1.000	1.000	0.962	0.984	1.000
51	Child "Coverage From" (additive)	From Birth		0.000		0.000	
52	Pre-Admission Certification Factor - Yes	1.000					
53	SIC Factor - No	1.000					
54	Final Total Manual Costs		$66.43	$76.34	$43.59	$96.00	$151.12

Exhibit II

Tillinghast-Towers Perrin Medical Manuel Costs–1998
Out-of-Network Monthly Costs

Company Name	Montana Insurance Dept	Effective Date:	September 1998	Pre-admission Certification:	Yes
Plan Name	State Basic Plan	Rates Guaranteed:	12 months	Deductible Plan Type:	All Expenses
Sub Name	Out-of-Network, no EAP Cou	Medical Area:	A	PPO Participation:	0%
		SIC:	No Adjustment		

		Input	Employee	Spouse	Children	Comp. Dep	Retiree
1	Base Cost:		$107.77	$126.68	$72.34	$162.30	$239.85
2	Calendar Year Deductible [illegible]	$750					
3	Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4	Eliminate Carry-Forward	Yes	(4.80)	(4.80)	(2.93)	(6.25)	(8.58)
5	Deductibles Per Family	4.00			(5.79)	(4.34)	
6	Hospital Deductible Per Admission	$0	0.00	0.00	0.00	0.00	0.00
7	Waive Deductible for Surgery						
	Policy Specifications:						
8	In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9	In-full Hospital Amount	$0	0.00	0.00	0.00	0.00	0.00
10	ICU Maximum	Unlimited	1.21	1.21	0.80	1.81	4.43
	Covered Level:						
11	Room and Board	$503	0.00	0.00	0.00	0.00	0.00
12	Surgical	$97	0.00	0.00	0.00	0.00	0.00
13	Adjusted Base Cost:		$104.18	$123.09	$64.42	$153.32	$236.70
	Coinsurance - General:						
14	First Coinsurance Percentage	75%					
15	on first $x Incumd after deductible	$5,000					
16	Second Coinsurance Percentage	100%					
17	on next $Y Incumd	$0					
18	Third Coinsurance Percentage	0%	9.47	10.09	3.49	11.45	28.78
19	Stop-loss Max Per Family	3.00			0.00	0.00	
20	Lifetime Maximum (omit 000's)	$1,000	0.00	0.00	0.00	0.00	0.00
	Mental Health and Substance Abuse:						
21	OP - Coinsurance	50%					
22	OP - Max Covered Charge	$2,000					
23	OP - Annual Maximum	$0					
24	Include OP Substance Ab —	Yes					
25	OP Adjustment Factor	1.00	7.85	7.85	6.45	11.34	18.44
26	IP - Max Days	30					
27	IP - Adjustment Factor	0.79	(1.09)	(1.28)	(0.46)	(1.40)	(2.42)
	Extended Care Facility:						
28	ECF Daily Benefit	$252					
29	ECF Maximum Number of Days	70	1.51	1.76	1.26	2.52	9.05
	Policy Specifications:						
30	Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31	Supplemental Accident Maximum	$0	0.00	0.00	0.00	0.00	0.00
32	Eliminate Rx Drugs	Yes	(9.23)	(10.85)	(6.20)	(13.90)	(20.55)
	Co-payments:						
33	Primary Office Visit Co-pay	$15					
34	Specialist Office Visit Co-pay	$15					
35	Max Number of Co-pays Per Year	100	1.19	1.34	4.90	4.40	(1.26)
36	Emergency Room Co-pay	$0	0.00	0.00	0.00	0.00	0.00
37	Outpatient Surgical Center Co-pay	$0	0.00	0.00	0.00	0.00	0.00
	Misc. Out-of-Network Adj.:						
38	Misc. Adjustment		0.00	0.00	0.00	0.00	0.00
	Well Care Benefit:						
39	Nursery Benefits - Maternity On Children	$800					
40	Adjustment Factor	1.00	[illegible]	[illegible]	[illegible]	[illegible]	
41	Well Care Benefits, Adult - No	NA					
42	Total Expense Limit	NA	0.00	[illegible]		0.00	[illegible]
43	Well Care Benefits, Children - Phy Exam Only	No Anc Lmt					
44	Total Expense Limit	$148					
45	Benefits Terminate Upon Attainment of Age	6			3.20		
46	Manual Cost: (before factor adjustments)		$114.48	$134.34	$78.06	$169.95	$265.74
	Factor Adjustments:						
47	Experience Factor	0.526					
48	Underwriting Factor	1.030					
49	Trend Factor	1.0140					
50	Age Gender Factor	Yes	1.000	1.000	0.952	0.984	1.000
51	Child "Coverage From" (additive)	From Birth		0.000		0.000	
52	Pre-Admission Certification Factor - Yes	1.000					
53	SIC Factor - No	1.000					
54	Final Total Manual Costs		$62.93	$73.84	$48.86	$91.97	$146.07

Tillinghast-Towers Perrin Prescription Drug Card Manual Costs–1998

Prescription Drug Card *Costs*

Company Name: Montana Insurance Dep't
Plan Name: State Basic Plan
Sub Name: In-Network, no EAP Couns

Effective Date: September 1998
Rates Guaranteed: 12 months
Medical Area: B
SIC: No Adjustment

Pre-admission Certification: Yes
Deductible Plan Type: All Expenses

Base Cost:	Input	Employee	Spouse	Children	Comp. Dep	Retiree
		$14.68	$16.15	$11.11	$21.92	$47.58
Include Birth Control as a covered expense?	No					
Average Prescription Cost						
Percent of Retail	NA	0.00	0.00	0.00	0.00	0.00
Other	NA					
Retail	$33.55					
Benefit Design						
Co-pay per prescription						
Brand	NA					
Generic	NA					
Annual Deductible	$50.00					
Coinsurance Percentage:						
Brand Name	70.00%					
Generic	90.00%					
Age Gender Factor Adjustment		0.00	0.00	0.00	0.00	0.00
Trend Factor using 1.4% Monthly Trend		0.41	0.45	0.31	0.61	1.33
Apply Major Medical Offset	No	0.00	0.00	0.00	0.00	0.00
Net Monthly Manual Cost:		15.09	16.60	11.42	22.53	48.91
Administrative Costs						
Per Prescription	$0.00	0.00	0.00	0.00	0.00	0.00
As a Percent Claims	0.00%	0.00	0.00	0.00	0.00	0.00
Additional Retention	0.00%	0.00	0.00	0.00	0.00	0.00
Final Gross Rx Drug Card Costs		$15.09	$16.60	$11.42	$22.53	$48.91

Exhibit V

Titlinghast-Towers Perrin Pmscription Drug Card Manual Costs–1998

Prescription Drug Card Costs

Company Name: Montana Insurance Dep't
Plan Name: State Basic Plan
Sub Name: In-Network, EAP Counselo

Effective Date: September 1998
Rates Guaranteed: 12 months
Medical Area: B
SIC: No Adjustment

Pre-admission Certification: Yes
Deductible Plan Type: All Expenses

Base cost:	Input	Employee	Spouse	Children	Comp. Dep	Retiree
		$7.51	$8.26	$6.26	$11.59	$22.30
Include Birth Control as a covered expense?	No					
Average Prescription Cost						
Percent of Retail		0.00	0.00	0.00	0.00	0.00
Other	NA					
Retail	NA					
	$33.55					
Benefit Design						
Co-pay per prescription						
Brand						
Generic	$30.00					
Annual Deductible	$10.00					
Coinsurance Percentage:	NA					
Brand Name						
Generic	100.00%					
	100.00%					
Age Gender Factor Adjustment		0.00	0.00	0.00	0.00	0.00
Trend Factor using 1.4% Monthly Trend		0.21	0.23	0.18	0.32	0.62
Apply Major Medical Offset	No	0.00	0.00	0.00	0.00	0.00
Net Monthly Manual Cost:		7.92	8.49	6.44	11.91	22.92
Administrative Costs						
Per Prescription	$0.00	0.00	0.00	0.00	0.00	0.00
As a Percent Claims	0.00%	0.00	0.00	0.00	0.00	0.00
Additional Retention	0.00%	0.00	0.00	0.00	0.00	0.00
Final Gross Rx Drug Card Costs		$7.72	$8.49	$6.44	$11.91	$22.92

Exhibit VII

CALCULATION OF THE BENCHMARK PLAN IP-ADJUSTMENT FACTOR (LINE 27 OF THE HEALTHMAPS OUTPUT) FOR AREA B

In-patient In-Network Mental Health Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming 80% of first $6250 and 100% for remaining days (30-day maximum)

In-Patient Days

Avg. Daily Cost: $848.70

Range	Average	Avg. Cost	Rotative Frequency	30 Days	Using 80% coinsurance forever (ala Tillinghast)
Under 10	5	$4,244	0.32	$4,244	
10-30	15	$12,731	0.4	$12,731	
30-60	45	$38,192	0.14	$25,481	
Over 60	70	$59.409	0.14		
		Expected annual cost		$13,579	
		Am't covered by plan		$12,329	$10,863

Ratio: Benchmark to Tillinghast: 113.49%

In-patient In-Network Substance Abuse Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming 75% of first $5,000 and 100% for remaining days (30-day maximum), $4,000 2-year maximum

In-Patient Days

Avg. Daily Cost: $254.61

Range	Average	Avg. Cost	Relative Frequency	30 Days	using 80% coinsurance forever (ala Tillinghast)	
Under 10	5	$1,273	0.32	$1,273	$1,273	
10-30	15	$3,819	0.4	$3,819	$3,819	
30-60	45	$11,457	0.14	$4,000	$11,457	
Over 60	70	$17,823	0.14			
		Expected annual cost		$3,055	$5,143	59.40% ratio to the due to the HealthMAPS cost due to ms $4,000 limi
		Expected am't covered by plan		$2,291	$4,114	55.69% ratio to HealthMAPS cost due to the 75% coinsurance to $5,000 and due to the $4,000 limit

Calculation of HealthMAPS Line 27 IP Adjustment Factor

HealthMAPS Claim Cost	Separated into Mental Health & Substance Abuse	Adjusted by the Benchmar to Tillinghast Ratio	Ratio of the Adjusted Total Claim Cost to the HealthMAPS claim cost
$2.44	$1.88	$2.13	
	$0.56	$0.31	
		$2.44	100.15%

CALCULATION OF THE BENCHMARK PLAN IP-ADJUSTMENT FACTOR (UNE 27 OF THE HEALTHMAPS OUTPUT) FOR AREA A

In-patient Out-of-Network Mental Health Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming
60% of first $3125 and *80%* for remaining days (to max. O-O-P)
(30-day maximum)

In-Patient Days

Range	Average	Avg. Cost	Relative Frequency	30 Days
Avg. Daily Cost: $776.25				
Under 10	5	$3,881	0.32	53,881
10-30	15	$11,644	0.4	$11,644
30-60	45	$34,031	0.14	$23,288
Over 60	70	$54,338	0.14	
		Expected annual cost		$12,420
			Ratio: Benchmark to Tillinghast	
		Am't covered by plan		$9,311 85.71%

In-patient Out-of-Network Substance Abuse Average Cost Calculation - Benchmark Plan

Recalculation of Tillinghast's example, assuming
75% of first $5,000 and 100% for remaining days
(30-day maximum), $4,000 2-year maximum

using *80%* *coinsurance* forever

In-Patient Days

Range	Average	Avg. Cost	Relative Frequency	30 Days	30 Days	
Avg. Daily Cost: $232.68						
under 10	5	$1,164	0.32	$1,164	$1,164	
10-30	15	$3,493	0.4	$3,493	$3,493	
30-60	45	$10,479	0.14	$4,000	$10,479	
Over 60	70	$16,301	0.14			
		Expected annual cost		$2,890	$4,704	61.43% ratio to the due to the HealthMAPS cost due to the $4,000 limi
		Expected am't covered by plan		$2,167	$3,763	57.59% ratio to HealthMAPS cost due to the 75% coinsurance to $5,000 and due to the $4,000 limit

Calculation of HealthMAPS Line 27 IP Adjustment Factor

HealthMAPS Claim Cost	Separated into Mental Health & Substance Abuse	Adjusted by the Benchmar to Tillinghast Ratio	Ratio of Adjusted Total Claim Cost to
$2.17	$1.67	$1.43	
	$0.50	$0.29	
		$1.72	79.22%

BENCHMARK PLAN ACTUARIAL VALUE ILLUSTRATION

	State Basic Plan In-Network Costs			State Basic Plan Out-of-Network Costs			State Basic Plan Blended Costs: In-/Out-of-Network			
	Percent of Base Cost	Children Claim Costs	Child Claim Costs	Percent of Base Cost	Children Claim Costs	Child Claim costs	Percent of Base Cost	Children Claim Costs	Child Claim Costs	Adjusted for Age Limit of 18
Base Cost (based on a $750 deductible and 75% coinsurance on next $5000, 100% thereafter)		$76.57	$40.30		$67.91	$35.74		$74.41	$39.16	$37.28
Inpatient Hospital	19.5%	$14.93	$7.86	19.5%	$13.24	$6.97	16.9%	$14.51	$7.64	$7.27
inpatient Professional	3.0%	$2.30	$1.21	3.0%	$2.04	$1.07	2.6%	$2.23	$1.17	$1.12
Inpatient Mental Health and Chemical Dependency		$2.93	$1.54		$2.05	$1.08		$2.71	$1.43	$1.36
Inpatient Surgical	4.4%	$3.37	$1.77	4.4%	$2.99	$1.57	4.4%	$3.27	$1.72	$1.64
Extended Care Facility		$1.36	$0.72		$1.26	$0.66		$1.34	$0.70	$0.67
Outpatient Hospitai	21.3%	$16.31	$8.58	21.3%	$14.46	$7.61	21.3%	$15.85	$8.34	$7.94
Outpatient Professional	2.1%	$1.61	$0.85	2.1%	$1.43	$0.75	2.1%	$1.56	$0.82	$0.78
Outpatient Mental Health and Chemical Dependency		$8.49	$4.47		$7.76	$4.09		$8.31	$4.37	$4.16
Outpatient Surgical	7.4%	$5.67	$2.98	7.4%	$5.03	$2.64	7.4%	$5.51	$2.90	$2.76
Diagnostic X-Ray & Lab	10.0%	$7.66	$4.03	10.0%	$6.79	$3.57	10.0%	$7.44	$3.92	$3.73
Office visits	18.9%	$20.14	$10.60	18.9%	$17.73	$9.33	18.9%	$19.54	$10.28	$9.79
Newborn Coverage		$1.47	$0.77		$1.34	$0.71		$1.44	$0.76	$0.72
Well Child Care		$2.62	$1.38		$2.40	$1.26		$2.57	$1.35	$1.29
Prescription Drugs		$8.93	$4.70		$8.93	$4.70		$8.93	$4.70	$4.47
vision Services		$0.97	$0.51		$0.85	$0.45		$0.94	$0.50	$0 47
Hearing Services Not Covered		$0.00	$0.00		$0.00	$0.00		$0.00	$0.00	$0.00
Other Miscellaneous	4.9%	$3.75	$1.97	4.9%	$3.33	$1.75	4.9%	$3.65	$1.92	$1.83
		$102.50	$53.95		$91.63	$48.23		$99.79	$52.52	$50.00

Exhibit X

Appendix A-30

Par Member Per Month *Cost* Distribution Model
1998 Medical Rate Manual

Type of Service	Annual Frequency per 1000 Members (A)	Utilization Adjustment Factor (B)**	Adjusted Utilization (A)*(B)=(C)	Cost per Unit of Service (D)	Discount Adjustment Factor (E)**	Adjusted Cost per Unit of Service (D)*(E)=(F)	Copay per Unit of Service (G)**	After Copay Cost per Unit (F)-(G)=(H)	Cost Per Member Per Year (C)*(H)=(I)	Final Adjustment Factor (J)**	Final PMPM (I)*(J)/12
Inpatient Hospital											
Medical	85 days		38.2	1,813.00	0.78	1,415.30	0.00	1,415.30	51.25	1.00	4.27
Surgical	80	0.43	36.7	2,175.60	0.78	1,698.36	0.00	1,698.36	85.76	1.00	5.48
ICU/CCU	52	0.48	22.2	4,532.50	0.78	3,538.25	0.00	3,538.25	78.38	1.00	6.53
Normal Delivery	22	0.07	1.5	2,175.60	0.78	1,698.36	0.00	1,698.36	2.59	1.00	0.22
C-Section	12	0.07	0.8	2,175.60	0.78	1,698.36	0.00	1,698.36	1.41	1.00	0.12
Other Maternity	2	0.07	0.1	2,175.60	0.78	1,698.36	0.00	1,698.36	0.24	1.00	0.02
Mental	59	Manual	0.0	1,118.00	Manual	0.00	0.00	0.00	0.00	Manual	0.00
Total	312		99.6	2,568.08		2,004.74		2,004.74	199.62		16.63
Outpatient Hospital											
Emergency Room	168 cases	0.62	104.8	270.00	0.78	210.77	4.50	206.27	21.61	1.00	1.80
Outpatient Surgery	76 cases	0.58	43.9	2,188.00	0.78	1,708.04	0.00	1,708.04	74.91	1.00	6.24
Radiology	210 cases	0.62	131.0	636.00	0.78	496.49	0.00	496.49	65.03	1.00	5.42
Pathology	158 cases	0.62	98.5	159.00	0.78	124.12	0.00	124.12	12.23	1.00	1.02
Other									106.00	0.48	4.30
Total									279.79		10.78
Physician											
Surgical Inpatient	49 procs	0.48	23.7	2,408.00	0.78	1,879.78	0.00	1,879.78	44.58	1.00	3.12
Surgical Outpatient	103 procs	0.58	59.4	1,290.00	0.78	1,007.03	0.00	1,007.03	59.86	1.00	4.99
Surgical Office	309 procs	0.58	178.3	147.00	0.78	114.75		114.75	20.40	1.00	1.11
Normal Delivery	11 cases	0.07	0.8	2,808.00	0.78	2,192.04	0.00	2,192.04	1.87	1.00	0.14
C-Section	3 cases	0.07	0.2	4,914.00	0.78	3,836.06	0.00	3,836.06	0.80	1.00	0.01
Maternity Other									13.00	0.05	0.06
Anesthesia									23.96	0.42	0.84
Professional Inpatient									78.53	0.37	2.39
Professional Outpatient									30.19	0.54	1.35
X-ray	612 procs	0.60	368.9	225.00	0.78	175.64	0.00	175.64	84.79	1.00	5.40
Lab	2,091 procs	0.60	1,260.2	45.00	0.78	35.13	0.00	35.13	44.27	1.00	3.63
Office Visits	4,437 visits	0.74	3,280.7	80.00	0.78	62.45	0.00	62.45	204.88	1.00	17.07
Total									587.01		41.42
Prescription Drugs	6,456 scripts	Manual	0.0	33.50	Manual	0.00	0.00	0.00	0.00	Manual	0.00
Miscellaneous											
Ambulance	20 trips	N/A	0.0	418.00	N/A	0.00	N/A	0.00	0.00	N/A	0.00
DME	31 items	N/A	0.0	312.00	N/A	0.00	N/A	0.00	0.00	N/A	0.00
Substance Abuse	29 days	Manual	0.0	838.50	Manual	0.00	0.00	0.00	0.00	Manual	0.00
Other									96.12	Manual	0.00
Total									96.12		0.00
Grand Total									1,162.54		76.84

** Columns B, E, G and J can be used to adjust the basic values to reflect user specified utilization, discounts, copays and other factors.

Exhibit XI

Page 1 of 1

Appendix A-31

Analysis of Cost Comparisons by Medical Procedure

Purpose: to convert the Tillinghast PMPM Blended Costs to Child Costs

Medical Area B	Annual Expenses				Child Expense as a Percent of the Blended Expense
	Employee	Spouse	Child	Blended	
Hospital Inpatient - Normal Mat	$55.34	$175.63	$4.61	$66.58	6.92%
Hospital Inpatient - All Other	$596.50	$652.11	$209.91	$492.76	42.60%
Hospital Inpatient - Total	$651.84	$827.74	$214.52	$559.34	38.35%
Hospital Outpatient	$424.31	$463.87	$234.55	$376.09	62.37%
Surgical Inpatient - Normal Mat	$38.47	$122.09	$3.21	$46.29	6.93%
Surgical Inpatient - All Other	$107.10	$117.08	$43.69	$90.27	48.40%
Surgical Inpatient - Total	$145.57	$239.17	$46.90	$136.56	34.34%
Surgical Outpatient.	$155.84	$170.37	$78.37	$135.80	57.71%
Professional Inpatient	$82.04	$89.69	$32.19	$68.77	46.81%
Professional Outpatient	$35.57	$38.89	$22.25	$32.30	68.88%
DX&L - Normal Maternity	$2.58	$8.19	$0.22	$3.11	7.08%
DX&L - All Other	$195.89	$214.15	$105.86	$172.90	61.23%
DX&L - Total	$198.47	$222.34	$106.08	$176.00	60.27%
Office Visits	$293.10	$320.43	$200.66	$271.38	73.94%
Prescription Drug	$204.65	$223.73	$96.06	$176.27	54.50%
Miscellaneous	$110.89	$121.23	$46.00	$93.70	49.09%
Maternity Total	$96.39	$305.91	$8.04	$115.	6.93%
Non-Maternity Total	$2,205.89	$2,411.55	$1,069.54	$1,910.	55.99%
All Expenses Total	$2,302.28	$2,717.46	$1,077.58	$2,026.	53.18%

Tillinghast-Towers Perrin Medical Manual Costs--1998
In-Network Monthly Costs

Company Name: Montana Insurance Dept
Plan Name: Children's Health Insurance
Sub Name: Actuarial Value Calculation

Effective Date: September 1998
Rates Guaranteed: 12 months
Medical Area: 8
SIC: No Adjustment

Pre-admission Certification: Yes
Deductible Plan Type: All Expenses
PPO Participation: 100%

	Input	Employee	Spouse	Children	Comp. Dep	Retiree
1. Base Cost:		$: 13.55	$181.19	$136.55	$253.64	$308.02
Deductible:						
2. Calendar Year Deductible (combined)	$0					
3. Deductible Accumulation Period	12	0.00	0.00	0.00	0.00	0.00
4. Eliminate Carry-Forward	Yes	0.00	0.00	0.00	0.00	0.00
5. Deductibles Per Family	3.00			0.00	0.00	
6. Hospital Deductible Per Admission	$0	0.00	0.00	0.00	0.00	0.00
7. Waive Deductible for Surgery						
Policy Specifications:						
8. In-full Surgical Units	0.00	0.00	0.00	0.00	0.00	0.00
9. In-full Hospital Amount	$0	0.00	0.00	0.00	0.00	0.00
10. ICU Maximum	3 Times R&B	0.00	0.00	0.00	0.00	0.00
Covered Level:						
11. Room and Board	$545	0.00	0.00	0.00	0.00	0.00
12. Surgical	$108	0.00	0.00	0.00	0.00	0.00
13. Adjusted Base Cost:		$153.55	$181.19	$136.55	$253.64	$308.02
13a. PPO Discount Value (at 99%)		0.00	0.00	0.00	0.00	0.00
Coinsurance - General:						
14. First Coinsurance Percentage	100%					
15. on first $x incurred after ded	$0					
16. Second Coinsurance Percentage	100%					
17. on next $Y incurred	$0					
18. Third Coinsurance Percentage	0%	65.26	77.01	58.03	107.80	130.06
19. Stop-loss Max Per Family	3.00			0.00	0.00	
20. Lifetime Maximum (omit 000's)	$1,000	0.00	0.00	0.00	0.00	0.00
Mental Health and Substance Abuse:						
21. OP - Coinsurance	80%					
22. OP - Max Covered Charge	$2,000					
23. OP - Annual Maximum	$0					
24. Include OP Substance Abuse	Yes					
25. OP - Adjustment factor	1.00	13.19	13.19	12.43	20.06	27.26
26. IP - Max Days	30					
27. IP - Adjustment Factor	1.00	0.00	0.00	0.00	0.00	0.00
Extended Care Facility:						
28. ECF Daily Benefit	$0					
29. ECF Maximum Number of Days	0	0.00	0.00	0.00	0.00	0.00
Policy Specifications:						
30. Waiver Of Coinsurance For OP Surgical	None	0.00	0.00	0.00	0.00	0.00
31. Supplemental Accident Maximum	$0	0.00	0.00	0.00	0.00	0.00
32. Eliminate Rx Drugs	Yes	(25.16)	(29.69)	(22.36)	(41.57)	(50.15)
Co-payments:						
33. Primary Office Visit Co-pay	$0					
34. Specialist Office Visit Co-pay	$0					
35. Max Number of Co-pays Per Year	0	4.30	4.84	5.02	7.67	8.78
36. Emergency Room Co-pay	$5	0.32	0.36	0.48	0.64	0.27
37. Outpatient Surgical Center Co-pay	$0	0.00	0.00	0.00	0.00	0.00
a=%%% [illegible]		0.00	0.00	0.00	0.00	0.00
Well Care Benefit:						
39. Nursery Benefits - Maternity On Children	$656					
40. Adjustment Factor	1.00	0.66	2.56	1.47	2.43	
41. Well Care Benefits, Adult - No	NA					
42. Total Expense Limit	NA	0.00	0.00		0.00	0.00
43. Well Care Benefits, Children - Phy and Gyn Exams	No Ano Limit					
44. Total Expense Limit	$500					
45. Benefits Terminate Upon Attainment of Age	no Limit			10.19		
46. Manual Cost: (before factor adjustments)		$212.11	$249.45	$201.79	$350.66	$422.24
Factor Adjustments:						
47. Experience Factor	0.526					
48. Underwriting Factor	1.000					
49. Trend Factor	1.0120					
50. Age Gender Factor	Yes	1.000	1.000	0.952	0.984	1.000
51. Child "Coverage From" (additive)	From Birth		0.000		0.000	
52. Pre-Admission Certification Factor - Yes	1.000					
53. SIC Factor - No	1.000					
54. Final Total Manual Costs		$112.97	$132.86	$102.32	$183.79	$224.88

Tillinghast-Towers Perrin Prescription Drug Card Manual *Costs–1998*

Prescription Drug Card Costs

Company Name: Montana Insurance Dep't
Plan Name: Children's Health Insuranc
Sub Name: Actuarial Value Calculation

Effective Date: September 1998
Rates Guaranteed: 12 months
Medical Area: B
SIC: No Adjustment

Pre-admission Certification: Yes
Deductible Plan Type: All Expenses

	Input	Employee		Children	Comp. Dep	Retiree
Base Cost:		$23.49	84	$19.58	$36.24	$69.7
Include Birth Control as a covered expense?	Yes					
Average Prescription Cost		0.00	00	0.00	0.00	
Percent of Retail	NA					
Other	NA					
Retail	$33.55					
Benefit Design						
Co-pay per prescription						
Brand	NA					
Generic	NA					
Annual Deductible	$0.00					
Coinsurance Percentage:						
Brand Name	100.00%					
Generic	100.00%					
Age Gender Factor Adjustment		0.00		0.00	0.00	
Trend Factor using 1.4% Monthly Trend				0.55	1.01	
Apply Major Medical Offset	NO	0.00	0.00	0.00	0.00	0.00
Net Monthly Manual Cost:		24.15	26.56	20.13	37.25	71.70
Administrative Costs						
Per Prescription	$0.00	0.00		0.00	0.00	0.00
As a Percent Claims	0.00%	0.00		0.00	0.00	0.00
Additional Retention	0.00%	0.00		0.00	0.00	0.00
Final Gross Rx Drug Card Costs						

Children's Health Insurance Program

Inpatient Mental Health
Calculation using Montana's minimum requirements from 33-22-703, MCA.

$848.70 = the Montana average cost per day

Inpatient Days

Range	Avg. No. of Days	Relative Frequency	Avg. Cost 21 days max.
Under 10	5	0.32	$5,175
10-21	13	0.24	$13,455
21-30	23	0.16	$21,735
30-60	45	0.14	
Over 60	70	0.14	
			$14,449

Am't covered by plan	$14,449
Annual frequency	0.00135
Annual cost per child	$19.51
Monthly cost per child	$1.63
Increased 20% for partial hospitalization coverage	$1.95

Outpatient Mental Health
See page 177,1998 Tillinghast State Mandated Benefits Manual
Maximum 20 annual visits, $100 charge per visit, no copay $4.15
Montana monthly cost per child $5.19 for outpatient mental health

Inpatient Chemical Dependency
Calculation using Montana's minimum requirements from 33-22-703, MCA.

$254.61 = the Montana average cost per day

Inpatient Days

Range	Avg. No. of Days	Relative Frequency	Avg. Cost $4,000 max.
Under 10	5	0.32	$1,235
10-21	13	024	$3,211
21-30	23	0.16	$4,000
30-60	45	0.14	
Over 60	70	0.14	
			$2,926

Area B

Expected am't covered by plan	$2,926
Biennual frequency	0.0027
Biennual cost per child	$7.90
Monthly cost per child	$0.33
Increased 20% for partial hospitalization coverage	$0.39

Outpatient Chemical Dependency
See page 177.1998 Tillinghast State Mandated Benefits Manual
Maximum yearly benefit of $1,000 $0.78
Montana monthly cost per child $0.98 for outpatient chemical dependency

Exhibit XV

CALCULATION OF THE ACTUARIAL VALUE FOR THE MONTANA CHILDREN'S HEALTH INSURANCE PROGRAM
Including Cost Calculation for the Benefits not Included in the HealthMAPS PMPM Program's Assumptions

	Base Cost	Area B Conversion Factor	Coverage to Age 19 Conversion Factor	Adjusted Cost
Newborn Children	$0.77	1.00	0.952	$0.73
Inpatient Mental Health	$1.95	1.00	0.952	$1.86
Inpatient Chemical Dependency	$0.39	1.00	0.952	$0.37
Immunizations	$1.84	0.82	0.952	$1.44
Well Child Care	$5.36	1.00	0.952	$5.10
Prescription Drugs	$10.31	1.00	0.952	$9.82
Outpatient Mental Health	$5.19	1.00	0.952	$4.94
Outpatient Chemical Dependency	$0.98	1.00	0.952	$0.93
Vision	$0.83	0.82	0.952	$0.65
Audiology	$0.04	0.82	0.952	$0.03
			Total	$25.87
Grand Total from the 1998 PMPM Spreadsheet				$76.84
Total Actuarial Value				$102.71

Monthly cost comparisons by category based on the
1998 Medical Manual's traditional plan distribution of expenses

	Benchmark	CHIP
Inpatient Hospital	$7.27	$11.15
Inpatient Professional	$1.72	$7.22
Inpatient Mental Health and Chemical Dependency	$1.36	$2.23
Inpatient Surgical	$1.64	$5.48
Extended Care Facility	$0.67	$0.00
Outpatient Hospital	$7.94	$12.54
Outpatient Professional	$0.78	$8.05
Outpatient Mental Health and Chemical Dependency	$4.16	$5.87
Outpatient Surgical	$2.78	$6.24
Diagnostic X-Ray & Lab	$3.73	$9.09
Office Visits	$9.79	$17.07
Newborn Coverage	$0.72	$0.73
Well Child Care	$1.29	$6.54
Prescription Drugs	$4.47	$9.82
Vision Services	$0.47	$0.65
Hearing Services	$0.00	$0.03
Other Miscellaneous	$1.83	$0.00
TOTAL	$50.00	$102.71

Exhibit XVI

Comparison of the Actuarial Values of the Benchmark Plan and CHIP Plan

	Benchmark Plan	CHIP Plan	Ratio: CHIP to Benchmark
Inpatient and Outpatient Hospital Services	$15.21	$23.69	1.56
Physicians' Surgical and Medical Services	$16.09	$44.06	2.74
Laboratory and X-Ray Services	$3.73	$9.09	2.44
Well-Baby and Well-Child Care (including age-appropriate immunizations)	$2.01	$7.27	3.62
Coverage of Prescription Drugs	$4.47	$9.82	2.20
Mental Health Services	$5.52	$8.10	1.47
Vision Services	$0.47	$0.65	1.38
Hearing Services	$0.00	*$0.03*	ERR
Total	$47.50	$102.71	2.16

Appendix B

Supporting Documentation for Insurance Rate

Memo

To: Mary Dalton

Mary Noel

From: Margaret A M i ,ASA, MAAA

CC: Frank Cote'

Claudia Clifford

Date: 07/09/99

Re: Premium for CHIP effective 1/1/99, adjusted for trend, law changes, and corrections

---

Attached are the workpapers showing the calculation of the monthly premium for the Montana Children's Health Insurance Plan. The new premium is effective October 1,1999.

I made several adjustments in the calculation of this rate. First, since the effective date is 11 months later than what I had assumed when I calculated the original rates, I adjusted for the extra trend. This alone increased the rate by about 5%. Second, in the last pricing process I had made a couple of incorrect assumptions which had resulted in a lower rate than should have been the result Correcting these increased the rate by about 1%. Finally, I adjusted the mental health rates to account for changes in the mental health and chemical dependency coverage law, for the effect of the mental health coverage parity law, and for the effect of covering the severely mentally ill children which were assumed to be covered by MHAP in the original pricing process; and I adjusted the chemical dependency rates to account only for changes in the mental health and chemical dependency coverage law.

The final monthly premium amount is $100.88, a 12% increase over the current rate of $90.01. The increases related to mental illness and chemical dependency account for about 6% of the premium increase in premium. I determined that two other law changes –those of prohibiting coverage of birth control and of adding an advance practice registered nurse as a covered provider – have no effect on the premium.

Exhibit I of the worksheets shows the calculation of the total monthly CHIP premium, in the same format as I used in the original pricing process. Exhibits II and III show the HealthMAPS PMPM pricing tables for the copay and no-copay plans respectively. Exhibit IV shows the calculation of the inpatient and outpatient mental health premiums that are shown in the first column of Exhibit IV, and Exhibit V shows the calculation of the chemical dependency premium; inpatient and outpatient costs were calculated separate, then the two rates were blended to come up with the single chemical dependency coverage rate.

If you have any questions, please give me a call at 444-3848.

5 enc.

Exhibit III

Per Member Per Month Cost Distribution Model
1998 Medical Rate Manual

Type of Service	Annual Frequency per 1000 Members (A)		Utilization Adjustment Factor (B)**	Adjusted Utilization (A)*(B)=(C)	Cost per Unit of Service (D)	Discount Adjustment Factor (E)**	Adjusted Cost per Unit of Service (D)*(E)=(F)	Copay per Unit of Service (G)**	After Copay Cost per Unit (F)-(G)=(H)	Cost Per Member Per Year (C)*(H)=(I)	Final Adjustment Factor (J)**	Final PMPM (I)*(J)/12
Inpatient Hospital												
Medical				34.5	1,813.00	0.80	1,442.06	0.00	1,442.06	49.71	1.09	4.52
Surgical				36.0	2,175.60	0.80	1,730.47	0.00	1,730.47	63.79	1.09	5.80
ICU/CCU	52	"	0.41	21.1	4,532.50	0.80	3,605.15	0.00	3,605.15	76.03	1.09	6.01
Normal Delivery	22	"	0.01	0.3	2,175.60	0.80	1,730.47	0.00	1,730.47	0.5	1.09	0.05
C-Section	12	"	0.01	0.2	2,175.60	0.80	1,730.47	0.00	1,730.47	0.27	1.09	0.02
Other Maternity	2	"	0.01	0.0	2,175.60	0.80	1,730.47	0.00	1,730.47	0.06	1.09	0.00
Mental	59	"	Manual	0.0	1,116.00	Manual	0.00	Manual	0.00	0.00	Manual	0.00
Total	312	"		92.9	2,576.09		2,049.03		2,049.03	190.36		17.29
Outpatient Hospital												
Emergency Room	168	cases	0.59	99.8	270.00	0.80	214.76	0.00	214.76	21.42	1.09	1.95
Outpatient Surgery	76	cases	0.55	41.4	2,188.00	0.80	1,740.34	0.00	1,740.34	72.67	1.09	6.60
Radiology	210	cases	0.59	124.7	636.00	0.80	505.87	0.00	505.87	63.08	1.09	5.73
Pathology	158	cases	0.59	93.8	159.00	0.80	126.47	0.00	126.47	11.86	1.09	1.08
Other										106.00	0.M	4.55
Total										275.03		19.90
Physician												
Surgical Inpatient	49	procs	0.46	22.6	2,408.00	0.70	1,678.38	0.00	1,678.38	37.89	1.09	3.44
Surgical Outpatient	103	procs	0.55	56.6	1,290.00	0.70	899.13	0.00	899.13	50.88	1.09	4.62
Surgical Office	309	procs	0.55	169.8	147.00	0.70	102.46	0.00	102.46	17.39	1.09	1.58
Normal Delivery	11	cases	0.01	0.1	2,808.00	0.70	1,957.18	0.00	1,957.18	0.26	1.09	0.03
C-Section	3	cases	0.H	0.0	4,914.00	0.70	3,425.06	0.00	3,425.06	0.14	1.09	0.01
Maternity Other										13.W	0.01	0.01
Anesthesia										20.44	0.34	0.58
Professional Inpatient										80.28	0.28	1.86
Professional Outpatient										31.96	0.31	0.83
X-ray	612	procs	0.67	351.1	225.00	0.70	156.83	0.00	156.83	55.07	1.09	5.00
Lab	2,091	procs	0.57	1,199.8	45.00	0.70	31.37	0.00	31.37	37.63	1.09	3.42
Office Visits	4,437	visits	0.57	2,545.4	80.00	0.70	55.76	0.00	55.76	141.93	1.09	12.89
Total										486.92		34.28
Prescription Drugs	6,456	script	Manual	0.0	33.50	Manual	0.00	0.00	0.00	0.00	Manual	0.00
Miscellaneous												
Ambulance	20	trips	NIP	0.0	416.00	NIP	0.00	N/A	0.00	0.00	WA	0.00
DME	31	items	NIP	0.0	312.00	NIP	0.00	N/A	0.00	0.00	WA	0.00
Substance Abuse	29	days	Manual	0.0	838.50	Manual	0.00	0.00	0.00	0.00	Manual	0.00
Other											Manual	0.00
Total										98.12		0.00
Grand Total										1,048.42		71.48

** Columns B, E, G and J can be used to adjust the basic values to reflect user specified utilization, discounts, copays and other factors.

Exhibit V

Children's Health insurance Proaram

Inpatient Chemical Dependency
Calculation using Montana's minimum requirements from 33-22-703, MCA.

$356.54 = the Montana average cost per day

Inpatient Davs Ranae	Avg. No. of Davs	Relative Frequency	(incl. copay) Avg. Cost $6,000 limit	(excl. copay) Avg. Cost $6,000 limit
Under 10	5	0.32	$1,758	$1,783
10-21	13	0.24	$4,610	$4,635
21-30	23	0.16	$6,000	$6,000
30-60	45	0.14		
Over 60	70	0.14		
			$4,308.86	$4,322.86
		Area B		
Expected am't covered by plan			$4,309	$4,323
Biennual frequency			0.00135	0.00135
Annual cost per child			55.82	$5.84
Monthly cost per child			$0.48	$0.49
Increased 20% for partial hospitalization coverage			$0.58	$0.58

alculation of risk load for severe mentally illness

	outpatient	Inpatient
	0.37000	0.26000
	1.23333	1.30000

Outpatient Chemical Dependency
See page VII-6, 1998 Tillinghast Medical Manual
25% of cost of an outpatient mental health plan with same limit $1.89
Montana monthly cost per child $1.89 for outpatient chemical dependency, no copay
$1.88 for outpatient chemical dependency, with copay

	current (should have been)	Renewal No copay	Copay
Outpatient SA	$0.78	$1.89	$1.88
Inpatient SA	$0.60	$0.58	$0.58
Total	$1.38	$1.24	$1.23

Up 'til now outpatient limit was $1,000, but inpatient was 21 days combined with mental illness, max $8,000 over 2 years.

Out-patient Mental Healt	Est. cost at various annual limits	Ratio of the fate to the annual limit	Ratio of the rate to the $1,000 limit plan's rate
1000 max	$3.12	0.3120%	
2000 max	$4.15	0.2075%	1.33013
3000 max	$5.10	0.1700%	1.63462
4000 max	$6.00	0.1500%	1.92308
5000 max	$6.75	0.1350%	2.16346
6000 max	$7.20	0.1200%	2.30769

Outpatient Substance Abuse $1.89 (25% of $6,000 limit plan's rate at 4% annual interest